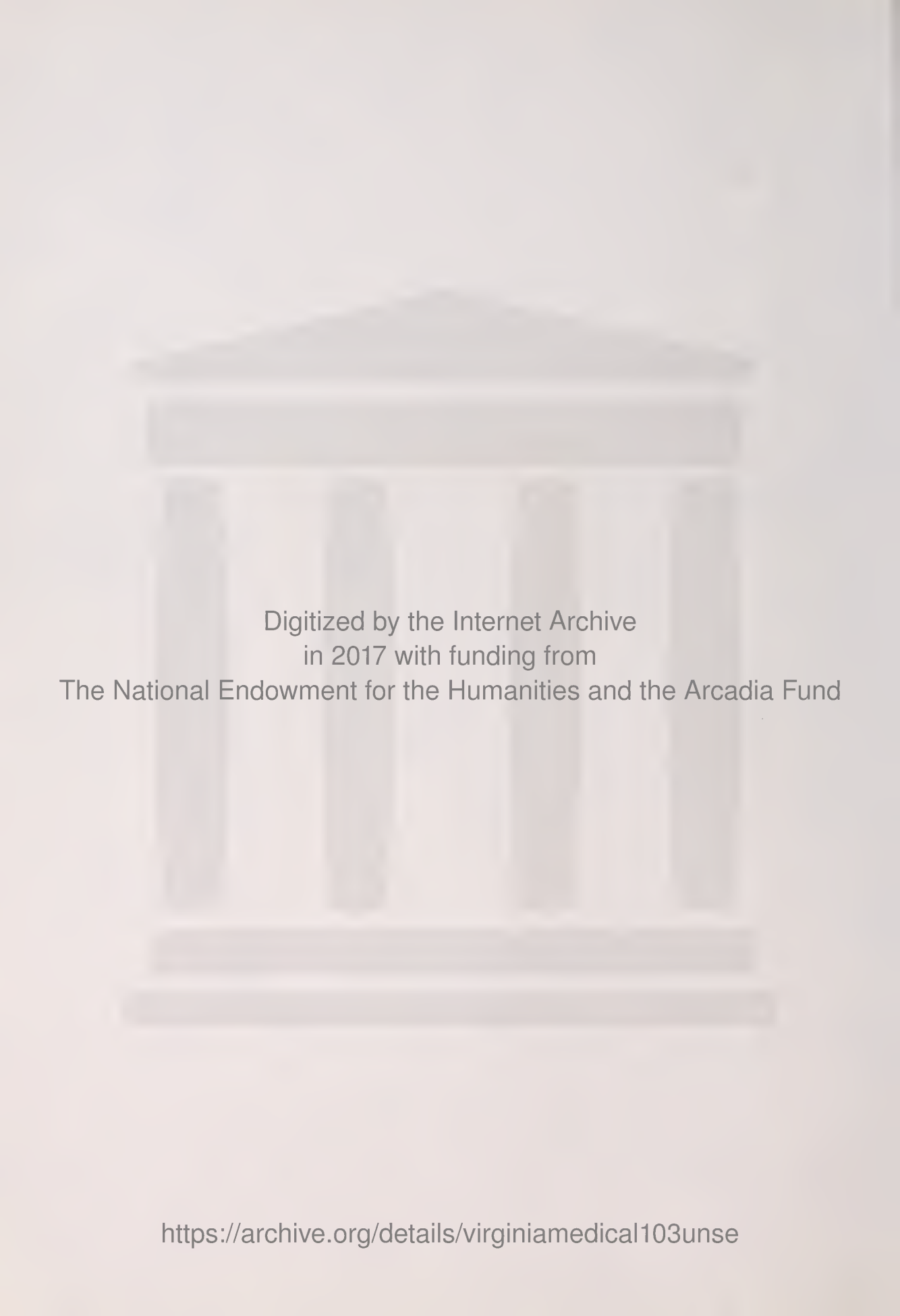
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VIRGINIA MEDICAL MONTHLY

OFFICIAL PUBLICATION OF THE MEDICAL SOCIETY OF VIRGINIA

Vol. 103
JANUARY
1976

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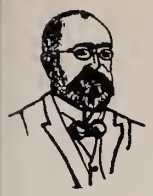


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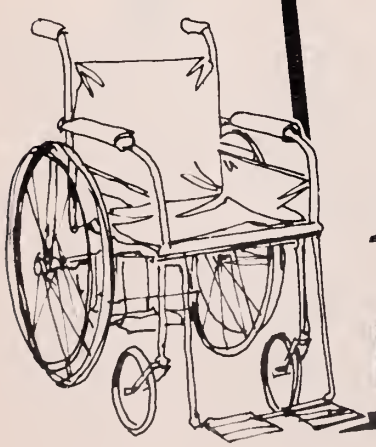
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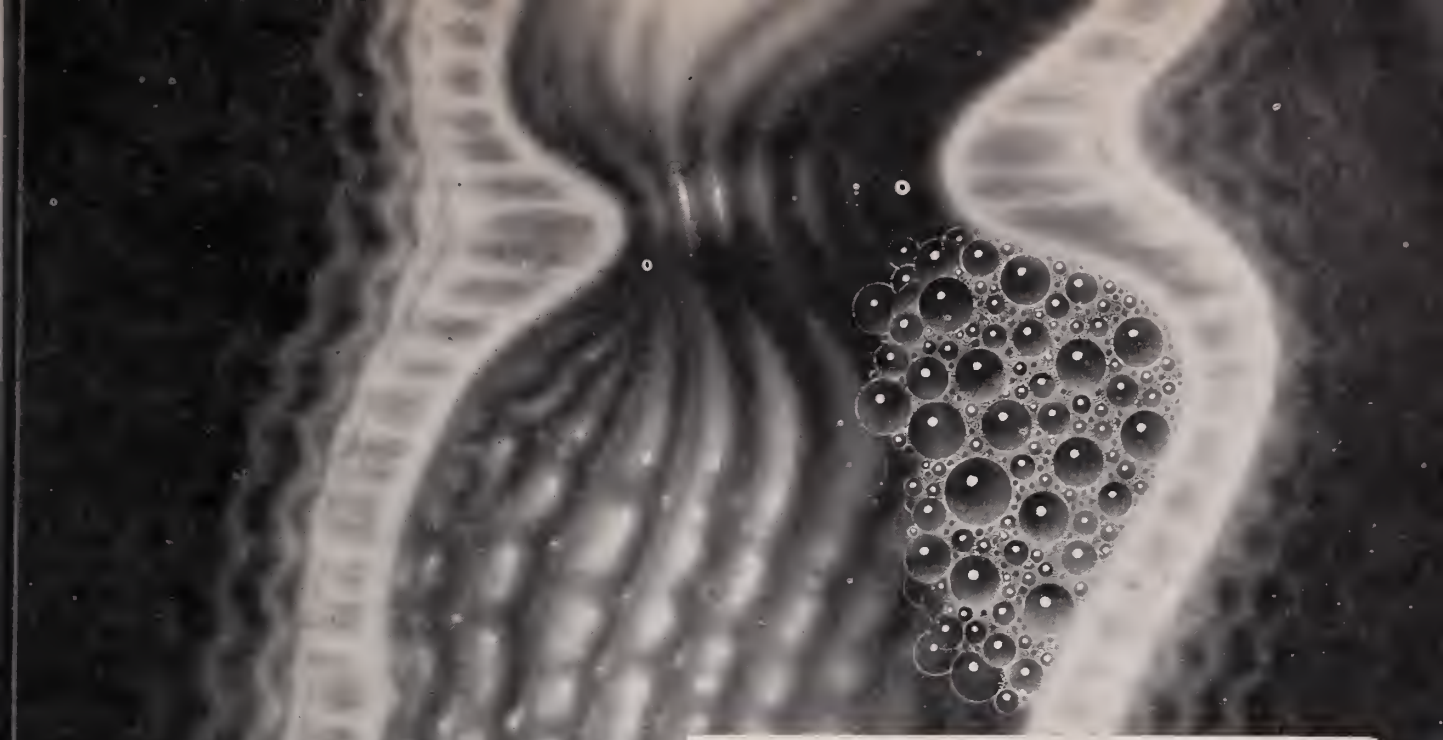
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Guest Editorial . . . .

Deans on the Go

DURING the 27 years that it has been my privilege to serve the people of the Commonwealth through the Virginia Council on Health and Medical Care, my association with the deans and other medical educators at our medical schools has been particularly rewarding to me. This has been especially true more recently. All three of our medical schools appointed deans from outside of Virginia who knew little or nothing about the state.

Shortly after coming to Richmond, Dr. Warren H. Pearse, former Dean, School of Medicine, Medical College of Virginia, Virginia Commonwealth University, requested that I take him on some of my routine trips so that he might become acquainted with physicians, community leaders, hospital administrators and their facilities. Dr. William R. Drucker, Dean, School of Medicine at the University of Virginia, asked to be included in the trips too. Later, a similar request came from Dr. Robert T. Manning, who at the time was Dean of Eastern Virginia Medical School. When Dr. Gerald H. Holman replaced Dr. Manning as Dean, he asked to be included on trips. When Dr. John R. Jones was appointed Executive Associate Dean of the School of Medicine at the Medical College of Virginia, Dr. Pearse wanted him to be given the same exposure to Virginia. Dr. Drucker included Dr. James W. Craig, one of his associate deans, on a trip to southwest Virginia. Dr. Harold B. Haley, Associate Dean of the School of Medicine at the University of Virginia, assigned to Roanoke, has made several trips with me. Dr. Edward J. Morrison of the Eastern Virginia Medical School represented Dr. Manning on one trip. Dr. W. Kenneth Blaylock, Assistant Dean for Graduate Medical Education, School of Medicine, Medical College of Virginia, has been out with me too.

To date 35 trips have been arranged for the deans. They have made 276 visits to communities and 144 visits to hospitals. Hospital administrators have been very thoughtful and generous in arranging meal functions for the deans which have involved their medical staffs and often members of their Boards of Trustees. Usually on our trips, meetings are scheduled at breakfast, lunch and dinner in order to make the most of time spent out of the office. Visits have been made in communities from Chincoteague to Grundy and Jonesville, and Winchester to Franklin and Stuart.

How have the deans reacted to these whirlwind safaris? In a recent letter, Dr. Pearse wrote, "From the standpoint of the School of Medicine at the Medical College of Virginia, visits to every part of the state by myself and Dean John Jones have been very helpful. I believe there are four benefits which we can cite specifically. First, we have met the physicians of Virginia face to face, learning of their own particular manpower problems and at the same time indicating to them our personal interest in them and in their problems and accomplishments. Second, we have visited almost every community hospital in the state and have gained an appreciation of both hospital facilities and the organization of medical practice in that region. Third, we

have met in most of these communities with hospital trustees and community leaders, again providing an opportunity to learn of their community problems and to indicate our interest in helping to provide solutions. Finally, we both have come to have a much better appreciation for the geography, economic resources, and health resources of the Commonwealth."

Dr. Drucker comments, "One of the happy thoughts in facing the New Year is that more trips with Edgar Fisher are being planned. On the basis of the trips I have made with you to all corners of the state since I started in Virginia in 1972, I have developed an appreciation of the subtleties and complexities of recruiting and retaining physicians in both rural and urban areas. I know this appreciation for the Edgar Fisher orientation for Health Care in Virginia Program is shared by our other Deans at the University of Virginia and those in other schools who have accompanied you on trips. . . . I look forward very much to our next trip as part of my continuing education about health care in Virginia."

Dr. Holman wrote, "I believe one of the major benefits to me of getting out to visit with physicians in Eastern Virginia has been to recognize the opportunities for rewarding practices in Eastern Virginia for our graduates, as well as to get a feeling for how we should shape our curriculum to train young men and women to meet the particular needs that clearly are required for the kind of practice one can envision in Eastern Virginia. Clearly it has been a rewarding experience, not only for me personally, to learn more about that part of the state of which our school must relate more and more in the future, but also a feeling for the kind of practice that many of our students clearly will enter."

How have physicians reacted to the deans' visits? Dr. Lawrence E. Southworth, President of the Medical Staff of the Mary Washington Hospital in Fredericksburg, wrote Dr. Pearse following his visit, "The Executive Committee of the Medical Staff appreciates the interest you have shown in our problems by spending some time at our hospital. Your visit served several purposes. Most of us had not met you previously, and we all can identify with the dean as 'a man who thinks like we do'. Secondly, your efforts toward solving the medical manpower problems are far more advanced and effective than any of us had imagined. Thirdly, this allowed re-establishment of a feeling of 'belonging' that some of the older physicians here have lost over the years."

Dr. Douglas K. Armbrister, President of the Medical Staff of the Smyth County Community Hospital in Marion wrote me, "I would like to express my appreciation for the meeting you arranged between our Medical Staff and Drs. Drucker and Craig. The deans made very favorable impressions on the doctors who were able to meet and talk with them this morning. . . . It is good to see the medical schools taking interest in the practical needs of small hospitals such as ours, as they certainly have much to contribute in the long range planning of the health care that we will be able to provide here."

On consecutive weeks Dr. Drucker and Dr. Pearse called on State Senator Elmon T. Gray in Waverly. Following their visits, Senator Gray wrote me, "I cannot possibly tell you the benefit it was for me to have this opportunity really to let my hair down with these two fine gentlemen. For the first time I had some real insight into just where we stand in Virginia on health care.

As you know, state legislators are besieged by constituents trying to get their sons or daughters into the health education field. Thanks to your visit with the deans, I have now got a much better perspective on the whole situation. I am also persuaded that Virginia is very fortunate to have two such outstanding men guiding our medical schools."

How do hospital administrators react to "Deans on the Go?" Robert A. Cramer, Immediate Past President of the Virginia Hospital Association and Administrator of Northampton-Accomack Memorial Hospital at Nassawadox states, "It is my opinion that the visitation of local hospitals by the deans of the three medical schools in the state is most worthwhile, inasmuch as it not only affords the nonteaching hospital an opportunity for dialogue on medical education and its problems between the deans and physicians of small hospitals, but also affords the deans an opportunity to become familiar with the attitude of practicing physicians about the need for medical education and its contents as viewed by these physicians practicing in small hospitals."

Governor Mills E. Godwin, Jr. added his word of endorsement to the deans' trips by commenting, "I commend our medical school deans and the Virginia Council on Health and Medical Care for the close cooperative relationship they have developed during the past several years. Through this relationship, the Virginia Council has given the deans a first-hand knowledge of the Commonwealth, its health and medical care needs, health problems and facilities. The deans have visited every section of our state, where they have strengthened and opened up lines of communication between their medical schools, the medical profession, hospitals, and consumers of health care. This unique undertaking on the part of medical school deans and the Virginia Council on Health and Medical Care should be encouraged."

There have been many exciting developments which have taken place in our fine medical schools here in Virginia during the past quarter of the century. To me one of the most encouraging has been the attitude of our medical school deans reflected in their interest and concern for the health and medical care in the Commonwealth. They have a sincere desire to see that their schools of medicine contribute as effectively as possible to making Virginia a better place in which to live and work.

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The Father Who Was Not a Father

M. J. V. SMITH, M.D.
Richmond, Virginia

GEORGE WASHINGTON assumed the first of his responsibilities, that of treasurer to the whole of the family, at the age of 16. Throughout his life he maintained a constant and consuming interest in the welfare of his relatives. One of the keenest disappointments of George Washington's life was that he never fathered any children of his own. It is not our intention to malign a great man but to examine the facts that are known to us and to speculate as to whether there was truly a medical reason why the Father of our Country apparently was infertile.

An entry in the family Bible in an unknown hand tells us that he was born on "ye 11th day of February 1732 about 10 in the morning, and was baptised the 5th of April following." The apparent discrepancy in these dates and the birthdate we celebrate is due to the fact that in 1752 the Calendar Amendment Act went into effect whereby the Gregorian was substituted for the Julian calendar and all dates were advanced 11 days.

Dr. Blanton, the Virginia historian, said that "he had a bad inheritance. His paternal forefathers were short lived, and there was a marked tendency to pulmonary disease amongst his ancestors". His great-grandfather, John, accompanied by his brother, Lawrence, settled in Virginia in 1656. The haunting fear of mortality that George Washington had all of his life after the age of 30 was always said to be due to his poor family record. It is far more likely that with his extensive acquaintance with medical men and medical matters, he was only too well aware that in Virginia, one of the southernmost of the original thirteen colonies, the average life expectancy was only 28 years.

We know something of his mother, Mary Ball Washington, and her family. She was Augustin's second wife, whom he married when she was 23. It is said that Washington's personal appearance and heritage were from this side of the family. His mother lived to 82, dying of cancer of the breast. She was a very self-willed woman who does not seem to have been very practical; indeed she could be described as a dependent personality who often humiliated her famous son by unfounded allegations of poverty and neglect.

Little is known about his health before the age of 15 except that he probably had had measles, mumps, and the "black canker" (a lay term for diphtheria) during his youth. It is likely that he was a sickly child who was subjected to a very domineering and possessive mother.

Certainly he was glad to be placed under the guardianship of his brother Lawrence shortly after his father died in 1743. It was through Lawrence's influence that young George learned the pleasures and ambitions of a young Virginia planter. He soon began to love the outdoors and became an excellent horseman. It was Mary Washington who vetoed the brother's plans for George to enter the British Navy after she had been advised by her English brother that George would not have hope for advancement because he was a colonial. So it was that he enlarged his mathematical ability and after a short period of practical experience was licensed by the President and Fellows of William and Mary as a Surveyor of Culpepper County at the age of 17. This was an important step in his life as a surveyor was always paid in cash money. Not long after this he was confined to bed with the ague and fever and paid his first visit, as a proper Virginia gentleman, to Warm Springs. This was probably his first severe attack of malaria. The swampland of Virginia

was infested with mosquitoes, and the majority of the population suffered with this disease. He had numerous recurrences of this problem (certainly in 1761, 1768 and 1769). In 1786 his close personal friend and physician, Dr. James Craik, dosed him for the first time with the new Jesuit bark which contained cinchona, now used as a source of quinine. That he was convinced of the efficacy is recorded by Thomas Lear, his secretary, to whom he wrote in August, 1798, "if you have missed the ague cure and the bark is necessary to prevent a relapse . . .". Dr. James Craik was in the habit of giving large doses of the bark quite frequently. To two of Washington's nephews he administered 13 ounces in the course of a year. Indeed, it is possible that this was responsible for George Washington's deafness with which he was so troubled in later life. Recurrent attacks of malaria plagued Washington throughout his life and, indeed, may have been responsible for some of his bouts of severe dysentery and fever that he frequently reported in his diaries. It is possible, too, that this disease or the drugs may have been a factor in his infertility. There are a few reports in the literature of malaria causing orchitis. However, it is known that it possibly causes infertility by the debility and recurrent fevers that occur in this disease, giving rise to defective spermatogenesis.

Washington was accustomed to vigorous outdoor exercise. As surveyor, explorer, and Indian fighter, he became used to the hardships of exposure to the elements and rigors of campaign. While still in his teens, he worked weeks at a time in unexplored hills and virgin forests, sleeping on cold, damp ground without cover or shelter. He was known to be fond of outdoor games and was said to have excelled in some of these as well as in feats of strength. He often rode on horseback about 15 miles a day, sometimes for three to five days in a single week, and when fox hunting he was in the saddle all day. This continual exercise and training is believed to have developed his unusual powers of resistance to the infections which attacked him on many, many occasions. In addition to fox and bear hunting he liked duck shooting, fishing, and horse racing. Between 1768 and 1774, he went fox hunting 155 times, attended the races 61 times, went to the theatre 37 times, went gunning 21 times, and attended 29 balls. He is said to have been an unusually proficient and graceful dancer, perhaps the best in Virginia. His habits were regular and methodical. He always rose early and retired early. When at home in Mount Vernon it was his habit to get up at 4:30 or 5:30 a.m., often making his own fire; after a little work in his library and a visit to the stables, he would have breakfast about 7:00 a.m. He held steady to the practice of retiring at 9:00 p.m., even with company in the house. He was obsessed with punctuality. On one occasion during his Presidency, his secretary apologized for being five minutes late, explaining that his watch had stopped. "Then, sir," retorted Washington, "either you must get a new watch or I must get a new secretary." Washington drank alcohol freely and liked to take two glasses of old Madeira with his dinner. When guests were present, it was the custom to drink a glass for each toast offered. At a State dinner once, thirty-one toasts were drunk. General Putnam, who was one of the participants, had to be carried to his quarters, but, as a proper gentleman, Washington apparently held his liquor well.

His appearance was striking. He was 6′ 2½″ tall, and his weight varied at different times in his life between 175 to 220 pounds. Washington himself stated that he "held usually steady at or around 200 pounds". In his description of Washington in 1760, George Mercer, his doctor friend who died in the Battle of Princeton, says,

"His frame is padded with developed muscles indicating great strength. His bones and joints are large as are his feet and hands. He is wide shouldered, but has not a deep or round chest; he is neat waisted, but is broad across the hips and he has rather long legs and arms. His head is well shaped, though not large. [This is interesting in that in the measurements taken after his death the circumference of his head was said to be 26⅞″, which would indicate a head of extraordinary size.] A large, straight, rather prominent nose, blue-grey penetrating eyes which are wide-

ly separated and overhung by a deep heavy brow. His face is long rather than broad with high round cheekbones and terminates in a good firm chin. He has a clear, though rather colorless pale skin which burns with the sun. Dark brown hair. His mouth is large and generally firmly closed, but which from time to time discloses some defective teeth. His features are regular placid. His voice is agreeable rather than strong."

There are several portraits of Washington made in his declining years, the latest of which there is record is a profile head drawn by a French artist in 1798. Strangely enough, the next latest was made in 1797, by Dr. Dick, one of his consulting physicians in his last illness.

There is a pastel drawn in 1794, by Williams, a fellow Mason from Alexandria Lodge, of which Washington was a past Grandmaster. It was supposed "to be as perfect a likeness as possible"; in it are reproduced all the lines of the face and his pockmarked nose. One gets an impression of decrepitude and, from contemporary discussion, this should be regarded as a caricature. The most famous portrait of Washington, and that with which most Americans are familiar, is the one done by Gilbert Stuart which was painted when Washington was 64. It probably is a completely inaccurate and stylized aggrandizement of the hero, so much so that his family refused to accept it; Stuart's widow later gave it to the Athenaeum Society of Boston. Charles Wilson Peale painted many full length portraits of General Washington in which he always depicted him as a virile man. His earliest portrait was done at the age of 42 for his wife and depicts him as he was when he married Martha; that is to say, he is dressed in the uniform of the Virginia Militia. It is interesting that the preliminary painting for this shows him dressed in red uniform while the full length shows the colonial green. There is an earlier portrait by Wollaston, but this has never been truly authenticated as Washington.

The most valuable representation of Washington is in the Houdon statue which was done from life. This was commissioned by the Virginia State Assembly and is now in the Capitol in Richmond. The head is completely accurate, having been taken from a life mask done by the sculptor himself in October, 1785. The peculiar position of the head and the expression on the General's face has upset many people because of the occasion that it depicts. It is just too prosaic for such a mythical person. Apparently Houdon had great difficulty in depicting the great man's character until one day while Washington was horse trading and muttered one of his better expletives to describe the price under discussion. Houdon, who was present, has recorded this moment for posterity as he left the scene, the outcome of which we do not know, muttering, "At last I have him, I have him!" The statue is life size and measures 6′ 2½″ in height, but, as is often the case, the body is not his. Governor Morris records, "The press is making a great ado over Houdon's statue of Washington, and I would have you know, it is a statue of me with Washington's head on it."

It is most interesting that most of the portraits show the right side of his face with considerable prominence. There is no doubt in my mind as to why this was so, as the life mask shows clearly the scar on the General's left cheek; indeed, this blemish caused Stuart some considerable problems. As yet, I have been unable to ascertain how this injury was received.

It is truly remarkable how difficult it is to find out what the man was really like.

Many of these physical and pictorial descriptions of Washington raise the interesting possibility that he may have harbored a form of Klinefelter's syndrome. A recent review of this syndrome indicates that George Washington may indeed have had this problem. He was infertile but apparently capable of normal sexual activity. He probably had hyperostosis of his frontal bones, accounting for the apparently large head. His hips were wide, and all who knew him remarked upon his remarkably large hands and feet. It is to be admitted that nowhere is it recorded that he had gynecomastia; however, his chest was described as being "turned in" towards the center, and it is conceivable that gynecomastia could have given this appearance. He also suffered from deafness, myopia, and bronchial disease, all of

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Effectiveness across the spectrum of most common forms of insomnia

Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



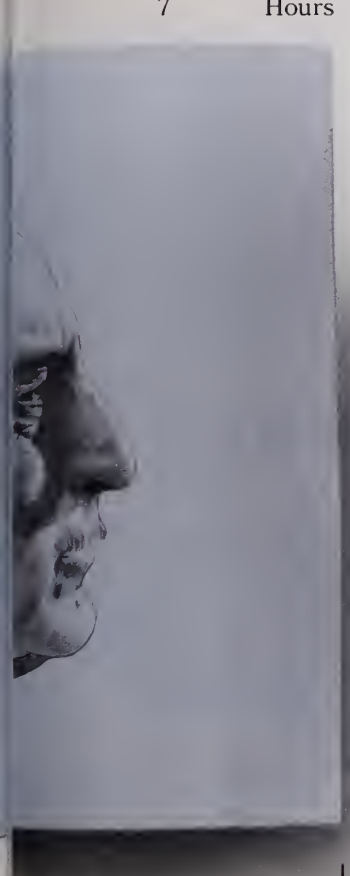
The insomnias most often occurring in young and older adults

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The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia



Awake too early



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One 30-mg capsule *h.s.*— usual adult dosage
(15 mg may suffice in some patients).
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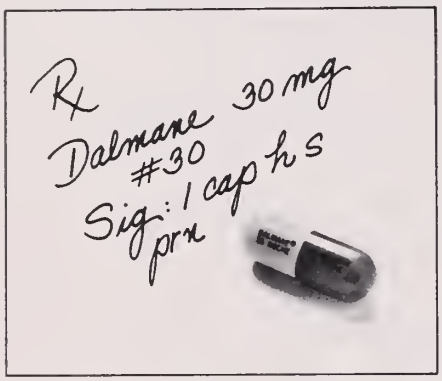
- ☐ induces sleep rapidly
- ☐ reduces nighttime awakenings
- ☐ lengthens total sleep time

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Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

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Objectively proved in the sleep research laboratory, Dalmane

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
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Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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4. Dement WC: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ



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which have been reported in Klinefelter's. Thus, his appearance and many of his medical problems can be said to fit very nicely into the overall picture of this syndrome. We lack only the cellular and modern sophisticated chemical studies to confirm the diagnosis. However, I am sure that had he consulted one of us today, this diagnosis would have been amongst those that we would entertain, particularly when we discovered his ambitious nature and somewhat psychoneurotic personality traits peculiar to a Klinefelter that has chromosomal makeup of XXXY.

When Washington was 11, his father died, and Washington came under the close influence of his half-brother, Lawrence. This was not a wise move in terms of his future health, as his brother, with whom he was very close (often described as his best friend), suffered from tuberculosis, which was the probable cause of death of all of Lawrence's children. In 1751, when George Washington was 19, he accompanied Lawrence to the Barbados where Lawrence had been sent in an effort to recover from his tuberculosis which had rendered him little better than an invalid. While in Barbados Washington was invited to the home of a friend for dinner where there resided a patient with smallpox. Washington, never one to refuse an invitation for fear of offending his host, accepted and in due time contracted the disease and had to remain under the care of Dr. Lanahan for one month. This experience made an indelible impression upon him and also speaks well of his powers of observation. He was one of the earliest proponents of inoculation; indeed he insisted that all of his family and slaves submit to this to protect them against smallpox. During the Revolutionary War a greater part of the time at Morristown was spent in inoculating the Army.

Washington's return trip from Barbados was calamitous, as he suffered severely with sea sickness, and he vowed he would never leave these shores again.

He returned to Mount Vernon, and soon after his return he succumbed to the "pleursie, which reduced me very low . . .". Most of us would regard this as his initial attack of tuberculosis, particularly when one remembers that he had been debilitated and in constant attendance upon his dying brother. Certainly he remained in poor health for the next two years.

In October, 1753, he was made an Adjutant of the Virginia Militia and was immediately ordered on a fruitless mission to the French Commander of the Ohio territory. During the next year he led a military expedition against the French at Fort Duquesne and was badly defeated; indeed his actions on this expedition are often said to have been the spark that started the Seven Years War. He had hardly returned when he was stricken with a severe attack of malaria. In 1755, at the age of 23, while still weak from this attack of malaria, he ventured to accompany the English general, Braddock, on his ill-fated campaign against the French at Fort Duquesne. However, his health would not stand the strain for very long, and he reported,

> "Immediately upon our leaving the camp at George's creek on the 14th . . . I was seized with violent fevers and pains in my head which continued without intermission until the 23rd, following when I was relieved by the General's absolutely ordering physicians to give me Dr. James' powders, one of the most excellent medicines in the world, for it gave me immediate ease and removed my fevers and other complaints in four days time. [This marvelous medicine consisted of antimony and calcium and phosphate.] My illness was too violent to suffer me to ride, therefore I was indebted to a covered wagon for some part of my transportation; but, even in this, I could not continue far for the jolting was so great, I was left upon the road with a guard, necessary to await the arrival of Colonel Dunbar's detachment."

On the day before the Battle of Monongahela, Washington rose from his sick bed, still weak and barely able to sit on his horse. The leading column under Braddock fell into a French-Indian ambush and was almost annihilated. Trying to rally his troops, Braddock received a mortal wound. Washington managed to extricate the remainder of the detachment after two horses had been killed under

him and his uniform pierced by four balls. He returned to Mount Vernon exhausted and wrote to one of his half-brothers, "I am not able, were I ever so willing, to meet you in town for I assure you that it is with some difficulty and much fatigue that I visit my plantations in the Neck; so much has a sickness of five weeks duration reduced me." So severe was this attack that he was compelled to resign from the Army. Later he wrote,

"I have never been able to return to my command, my disorders at times returning obstinately upon me, in spite of the efforts of all the sons of Aesculapius whom I have hitherto consulted. At certain periods I have been reduced to great extremity and have too much reason to apprehend an approaching decay [tuberculosis] being visited with several symptoms of such a disease. . . . I am now under a strict regime and shall set out tomorrow for Williamsburg to receive the advice of the best physicians."

It was on this trip that he met, for the first time, the widow, Martha Custis, his future wife.

Martha Dandridge in 1749, at the age of 17, married Daniel Park Custis and had four children, two of whom died in infancy. When her husband died in 1757, he left his widow a rich woman with two young children. On January 6, 1759, she married George Washington, who was almost the same age as herself. He immediately demonstrated his love for children and family life by assuming the guardianship of March (known as little Patsy) and George Park Custis. On these stepchildren he lavished attention and love. Patsy was a special favorite, and he was extremely distressed when she died of epilepsy at the age of 16. So great was his love of children that, after George Park Custis died in 1781 from dysentery acquired during the Revolutionary War, he adopted the two youngest of his four children, Nelly and George Washington Parke Custis.

Less than three years passed before Washington's health was again the object of concern. This time, in 1761, he was stricken with fever and on the advice of a parson, Dr. Charles Green, Rector of Pohick Church, he went to Warm Springs, was not relieved, and returned to Mount Vernon in what he described as "a very low and dangerous state. I thought the grim king would master my utmost efforts. Thank God I have now gotten the better of the disorder, and shall be restored, I hope, to perfect health again." He was well for awhile, but in 1768 and 1769 had recurrent attacks. Following this, and very fortunately for the history of our country, he was not visited with any severe illness until well after the Revolution. Indeed, it was 1786, one year after he assumed the Presidency, when he had his next bout of severe malaria.

That he should have had no children with Martha Washington is indeed surprising, particularly in view of her apparent fertility before she married him. Also, in the few letters of Martha's that are available, it is apparent that she always was hopeful that they would have a child and fulfill George Washington's deep sense of family. It is therefore possible that one must blame the male partner of this sterile marriage. In view of his strong family history of tuberculosis and his known attacks of this disease during his lifetime, it is very possible that he suffered from genito-urinary tuberculosis involving the epididymis or vas so that he became infertile. There were at least eight years between the onset of his original attack of tuberculosis and his marriage. His tuberculosis of the lungs had been arrested, or at least he was not infective, as is evidenced by the fact that none of his close stepchildren suffered with this disease. In more modern times genito-urinary tuberculosis has been said to be attendant with the most fearsome mortality. However, if one consults some of the earlier textbooks on urology, without exception the treatment recommended is open air life, exercise, and clean living. I think Doctors Guttierez, Keyser or Young would have been well satisfied with the progress of their eminent patient had he lived during their times.

(*References on page 33.*)

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Glomus Jugulare Tumor

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Three cases of glomus jugulare tumor were seen and treated at the Roanoke Ear, Nose and Throat Clinic between October 1971 and February 1972. Pertinent clinical details of these cases are discussed in order that the salient features of the disorder of glomus jugulare tumor and more recent techniques in management might be reviewed. In addition, the major reported thought on etiology and current trends in management are examined, hoping that this information will enhance our overall awareness of glomus jugulare tumors.

TUMORS OF THE GLOMUS JUGULARE occurring within the temporal bone were first described as a clinical entity by Rosenwasser in 1945.[1] Since that time much experience and knowledge has been gained in the diagnosis and treatment of this interesting and rather unusual disorder. At the present time well over 300 documented cases have been reported in the literature and numerous articles have been written with regard to the overall management of these cases. And yet, glomus jugulare tumors are still most often diagnosed in a relatively advanced stage and treatment methods frequently fail to adequately control the symptomatology and further progression of this disorder.

Presented before the Virginia Society of Ophthalmology and Otolaryngology.

To be sure, part of the problem is inherent in the fact that these tumors are usually benign and slow growing, and patients often do not develop significant symptoms until such time as the lesion has reached a rather advanced stage. In addition, early signs are frequently not diagnosed as a very high index of suspicion and thorough otological evaluation is required.

With these thoughts in mind, three recently diagnosed and treated cases of glomus jugulare tumors are being presented. Although this series is too small to represent any significant statistical conclusion, pertinent clinical details are being discussed in order that the salient features of this disorder and more recent techniques in management might be reviewed.

In addition, the major reported thought on etiology and current trends in management will be examined, hoping that this information might enhance our over-all awareness of glomus jugulare tumors.

Case Reports

The following three cases were seen at the Roanoke Ear, Nose, and Throat Clinic between October, 1971, and February 1972.

Case 1. A 73-year-old Negro female was admitted to the Roanoke Memorial Hospital on 10/12/71 following a 10-month history of noises in her right ear. Symptoms first began as an intermittant buzzing sound in the ear which progressed to a very loud pulsatile roaring noise heard all of the time. In addition, for several months she noticed a fullness and a slight decrease in hearing in her right ear. She did not complain of drainage, vertigo, bleeding, or neurologic problems. There was no past history of ear disease.

Physical examination with the hand otoscope revealed a normal appearing tympanic membrane with a reddish mass present filling the

posterior half of the middle tympanum. The posterior and inferior extent of it could not be ascertained. The incudo-stapedial area was obscured. With the Zeiss microscope, a smooth rounded mass was easily discernable filling the posterior middle tympanum and extending posteriorly and inferiorly an undetermined distance. A definite pulsation could be observed. The remainder of the ear, nose, and throat examination, including mriror examination of the nasopharynx and complete neurological evaluation, was normal.

Tuning fork tests revealed a negative Rinne at 250, 500, and 1000. A pure-tone audiogram revealed a mild bilateral high frequency sensori-neural loss slightly worse on the right with a right 10 to 15 decibel air bone gap.

X-rays revealed normal mastoids; however, PA and lateral tomograms of the jugular foramen revealed definite bone destruction on the right side (Fig. 1). A jugular venogram demonstrated complete occlusion of the right internal jugular vein (Fig. 2).



Fig. 1. PA tomogram of jugular foramina with destruction on right side.

Clinical impression was that of a glomus jugulare tumor involving and totally occluding the right internal jugular vein. On 10/14/71 a right exploratory tympanotomy was performed through a transcanal approach. Following careful dissection of the tympanic membrane off of the surface of the mass, a generous biopsy was obtained utilizing a large cup forceps. Bleeding was brisk; however, it was easily kept up with, with a large bone suction, and easily tampanoded with small bits



Fig. 2. Lateral jugular venogram with complete occlusion of jugular vein tumor.

of surgicel. The approximate blood loss was 20 cc.

Microscopic examination of the biopsy material showed a typical appearing glomus jugulare tumor with nests of polyhedral cells surrounding capillary spaces (Figs. 3 and 4).



Fig. 3. Polyhedral cells surrounded by capillary spaces.

This patient was referred for irradiation therapy. Following 5500 R of Cobalt 60 ir-

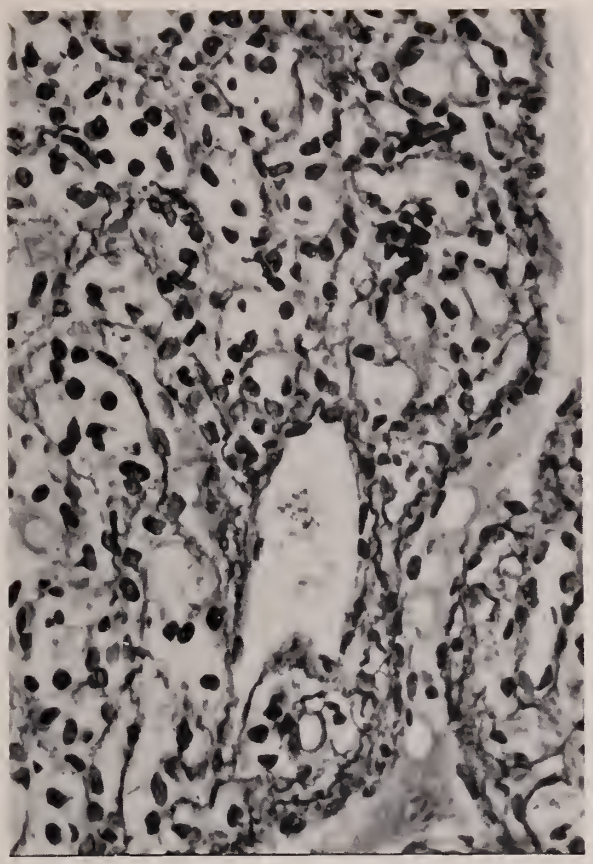


Fig. 4. Higher power view of Figure 3.

radiation, her tinnitus markedly improved. A repeat venogram at this time was unchanged.

Case 2. This 68-year-old white female was admitted in February of 1972, with a 5-year history of a roaring pulsatile noise in her right ear. In the spring of 1971 she began noticing a fullness and blocked feeling in her right ear. She was treated by her family physician with antihistamines and decongestants with no improvement. In addition she began noticing a significant loss of hearing on the right side and had difficulty localizing sounds and hearing on the phone. For 3 months before admission she noticed a dull aching pain in the right ear.

Physical examination with the hand otoscope revealed a reddish bulged appearance to the lower half of the right tympanic membrane. Microscopic examination showed a definite pulsatile mass pushing the lower half of the tympanic membrane laterally and extending superiorly to the handle of the malleus. The posterior and inferior margins could not be visualized.

Tuning fork examination revealed the Weber to the right at 250, 500, and 1000. The Rinne test was negative at all three frequencies. A pure-tone audiogram revealed high-tone sensori-neural loss bilaterally symmetric with a 15 to 20 decibel air bone gap on the right side.

X-rays including plain films of skull and mastoids, tomograms of jugular foramina, a right jugular venogram and right carotid arteriogram with subtraction all were normal.

These findings suggested a large glomus tympanicum tumor with extension into the posterior and hypotympanum.

The patient was taken to the operating room and the right ear explored through a post auricular incision. The canal skin was removed for better exposure. The tympanic membrane was thinned and densely adherent to the mass. This portion was left attached and transected superiorly. With small curettes and a small diamond burr the posterior tympanum and hypotympanum were exposed and the lower and posterior limits of the tumor visualized. With a small duckbill elevator and surgicel the lower edge was lifted and bluntly dissected. After avulsing the tumor from a small feeder vessel on the promontory it was easily removed intact. Bleeding was easily controlled with surgical packing. Approximate blood loss was 35 cc. The eardrum was reconstructed with a temporalis fascia graft and the canal skin put back in place. A rose bud packing was used. The packing was removed uneventfully in two weeks.

Pathology reported a glomus jugulare tumor.

Case 3. This 45-year-old Negro female was hospitalized in February, 1972. Chief complaint was that of problems with her left ear. Symptoms began one year prior with a gradual decrease in hearing in the left ear progressing to a point of difficulty with phone conversations. Two months prior to admission a roaring sound synchronous with her heart beat developed. This was worse in quiet surroundings and became extremely annoying to the patient. She had no other symptoms.

Physical examination with the hand otoscope revealed a red, bulging left tympanic membrane which at first appeared to be acute otitis media. With the microscope a large pulsatile reddish-blue mass was seen completely filling the middle ear space and obscuring all normal anatomical landmarks. The tympanic membrane was displaced laterally. Tuning forks revealed the Weber to left at 250, 500, and 1000. The Rinne was negative at all three frequencies. A pure-tone audiogram showed a 30 decibel air-bone gap on the left side. X-rays of the mastoid showed a sclerosis on the left side. Basal view and tomograms of the jugular foramen showed bone destruction. A left internal jugular venogram revealed a sharp cut off of the jugular vein close to the skull base (Fig. 5).

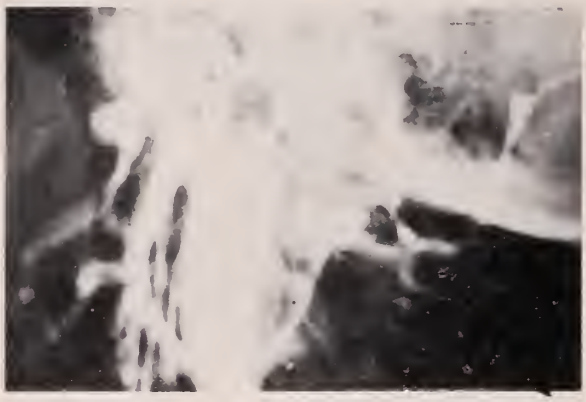


Fig. 5. Sharp cut off of jugular vein at skull base.

Clinical impression was that of a glomus jugulare tumor with obstruction of interval jugular vein. An exploratory tympanotomy confirmed that the middle tympanus was filled with tumor. A biopsy from the lower portion was obtained. Minimal bleeding was encountered and several bites were taken.

Pathology revealed a glomus jugulare tumor. She was referred for X-ray therapy.

Discussion

To begin a discussion of glomus jugulare tumor some of the etiological aspects should be mentioned. In earlier years problems related mainly to identity.

Guild[2] in 1941 described normally occurring structures resembling the carotid body, along the adventitia of the jugular bulb and in the floor of the middle ear along the course of Jacobson's nerve. He termed the name glomus jugularis. In 1953 Guild[3] reported an anatomical study of 88 temporal bones in which he found 248 glomus formations. All of these were in association with either Arnold's or Jacobson's nerves and about half were in the region of the jugular fossa. Innervation was found to be from non-medullated fibers of these nerves and blood supply from the tympanic branch of the ascending pharyngeal artery.

These jugular bodies resemble histologically the carotid body and are believed, but not proven, to share its function as a chemoreceptor responding to anoxemia[4].

In 1945 Rosenwasser[1] operated on a patient with a large vascular tumor of the middle ear which resembled histologically the normally occurring glomus formations described by Guild. Prior to this time sporadic reports of vascular tumors of the middle ear had been reported but it was not until this association that the true identity of these lesions was discovered.

Attempts at nomenclature are indicative of the general confusion surrounding the formation of the glomus body. Terms such as nonchromaffin paraganglioma, chemodectoma[5], and chemoreciptoma[6] are used. It is generally felt that this is paraganglionic tissue which, unlike the adrenal medulla, does not stain with chrome salts. Several case reports have demonstrated that these lesions may be nor-epinephrine secreting.[7,8] No definite receptor function has been proven.

Lundgren[9] divided glomus tumors into the glomus jugulare forming near the jugular bulb and glomus tympanicum forming on the promontory. This is of significance in that the glomus tympanicum may be diagnosed earlier with the early onset of tinnitus and hearing loss. Glomus jugulare produces symptoms usually later with growth and bone destruction occurring in the region of the jugular foramen prior to the onset of ear symptoms. Growth

may extend laterally into the soft tissues of the neck or medially into the nasopharynx.

With regard to the multiplicity of locations from which these tumors may arise and their relation to surrounding structures, varying symptoms may arise. Alford and Guilford[10] in reviewing 277 cases, found that hearing loss is the earliest symptom in 91% of cases. Following this are tinnitus, facial paralysis, discharge, pain, vertigo, bleeding, and palsies of cranial nerves IX, X, XI, and XII. In these three reported cases, hearing loss and tinnitus were the most prominent symptoms. Dull pain was a feature in two of the cases. Interestingly, the patient with the largest tumor had no pain, and despite significant bone destruction in two cases, cranial nerve findings were absent. This latter point may be due to the tendency for glomus tumors to follow normal bony channels.

All too often physical diagnosis presents no real problem, with the presentation of a polypoid bleeding mass in the ear canal. However, in earlier lesions symptoms are frequently subtle or absent. In these latter cases, every diagnostic tool should be utilized including the use of the Siegal otoscope and the operating microscope. In all cases presented much greater detail was observed with the use of the microscope. In one case presented, the initial appearance with the hand otoscope was that of an acute otitis media; however, with magnification a definite pulsatile mass could be delineated. Also, small glomus tympanicum tumors are not well seen without the aid of sharp focusing and magnification.

Hearing loss is present in almost all of the cases and it may be pure perceptive, pure conductive, or mixed. Glomus jugulare tumors have a propensity to follow normal bony channels and often involve the petrous directly producing a sensorineural deafness, and it is only later when the mass extends into the middle ear that a conductive element occurs. Glomus tympanicum tumors may produce no hearing loss until either the ossicular chain of the tympanic membrane is directly impinged upon producing a conductive type loss.

All patients with unilateral hearing loss and pulsatile tinnitus regardless of other findings should be studied radiologically. This should include at least skull films, mastoid films, and tomograms of the jugular foramen area. Two significant advances have greatly aided in the diagnosis of glomus tumor. Subtraction angiography, introduced by dePlantes, and retrograde jugular veinography introduced by Gejrot and Lauren[11,12,13,14].

Radiologic findings may include mastoid clouding, mastoid sclerosis, bone destruction in the jugular foramen area, extra- or intra-luminal distortion of the jugular bulb, or the demonstration of a vascular mass on angiograms. Positive findings both aid in the establishment of a tumor diagnosis and serve as a guide to further treatment efforts. In the three cases presented, despite similar physical findings radiologic findings were quite different, with total occlusion of the jugular vein in two cases and normal findings in the third. In this latter case, the negative X-ray findings led to the conclusion that complete surgical removal might be anticipated. Myers[15] has emphasized the fact that vascular studies also help to rule out the presence of a high jugular bulb with dehiscence of the floor of the hypotympanum, aneurysms of the carotid artery, or an aberrent course of the carotid artery through the temporal bone.

The approach to treatment should be governed by the origin or extent of tumor, the age and general condition of the patient, and finally, the experience of the otologist.

In an effort to present a workable guide to therapy, Alford and Guilford[10] classified these lesions into five clinical stages and outlined general measures of treatment for each. This classification is worth reviewing in that to date it represents the most useful one in managing these cases. Stage 0 lesions are those with hearing loss, tinnitus, intact tympanic membrane, normal hearing or conductive loss, normal X-rays, and no cranial nerve findings. Stage I lesions also may have discharge, bulging tympanic membranes, or a mass in the ear canal

and clouding but no erosion on X-rays. Stage II lesions may have added findings of facial paralysis, perceptive hearing loss, and enlargement of the jugular foramen. Stage III includes vertigo, hoarseness, erosion of the petrous bone, and cranial nerve palsies. Stage IV may be all of the other stages with added intracranial findings.

Alford and Guilford[10] recommend surgical removal by tympanotomy or hypotympanotomy for Stage 0 lesions. Stage I and II lesions are removed by radical mastoidectomy followed by radiation therapy. Stage III and IV are treated by radiation therapy alone.

If radiation therapy is used, an ideal dose of 4000 to 5000 R has been recommended[16].

Since these tumors are highly differentiated, that radiation therapy alone is curative is unlikely; however, clinically it has produced long term improvement in symptomatology and survival. The mechanism for this phenomenon is not known, but Rosenwasser and Meyers have demonstrated histologically marked initimal fibrosis in the smaller vessels following therapy. Whether or not there is a direct cellular effect is not known.

Finally, a brief mention of surgical procedures. For small tumors, Shambaugh[17] advocates a transcanal hypotympanotomy approach. McCabe and Fletcher[18] list four criteria for this approach; (1) the absence of bone destruction on X-rays, (2) conductive hearing loss only, (3) intact jugular foramen nerves, and (4) the absence of facial weakness. House[19] utilizes a similar approach; however, he removes the tympanic plate to expose the hypotympanum. If the lesion extends posteriorly behind the facial nerve, a posterior tympanotomy is used. For larger tumors extensive dissections have been described, including rerouting of the facial nerve, ligation and resection of the jugular bulb, and various other wide-field procedures. Hilding and Greenberg[20] presented a case recently in which a glomus tumor with posterior fossa extensions was completely removed by a combined suboccipital and transtemporal approach.

Summary

Three recently diagnosed and treated cases of glomus jugulare tumors have been presented. Major thoughts on etiology, diagnosis, and current management have been discussed. Although benign and slow growing, the glomus tumor occurring within the temporal bone may produce severe long term effects and should not be managed with any sense of complacency, but rather, beginning with a high index of suspicion, a deliberate, careful and thorough otologic investigation should be undertaken. Efforts should be made to determine if the lesion is a glomus jugulare or a glomus tympanicum. Tomography, retrograde venography, and carotid arteriography with subtraction are most helpful in this regard.

If X-ray studies are negative and there is no perceptive hearing loss or cranial nerve finding, complete surgical removal is the treatment of choice. The methods for this are well known. If, however, one encounters bone destruction, deformity of the jugular bulb, or cranial nerve deficit, the decision to attempt surgical removal should be based on the experience of the otologist and the age and general condition of the patient. At the present time, the advantages of more extensive surgical procedures over X-ray therapy are not clearly evident. Finally, all biopsies and anticipated surgical procedures should be performed under the most controlled conditions and the possibility of massive bleeding should be a foremost consideration.

As with many otologic conditions, the management of glomus jugulare tumors is by no means settled. As this is a relatively rare condition, experience across the country is varied and virtually no one has had personal experience with large numbers of these tumors. Meticulous observation and careful documentation of both diagnostic features and clinical results will not only aid in increasing our knowledge in this area but greatly enhance our effectiveness in the overall management of these cases.

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Can any doctor part with his copy of the December, 1975, Virginia Medical Monthly? The journal office is in very short supply and will greatly appreciate donations.

Patients, Please!

Dr. Gerald L. Brown, Society member and investigator at NIH, asks the help of his fellow physicians in a study of neuropsychiatric disorders in which he is participating. To be researched: in adults, presenile dementia, Huntington's chorea, Korsakoff's syndrome, tardive dyskinesia; in children, minimal brain dysfunction (hyperactivity) and Gilles de la Tourette's disease. The focus is largely biological, but psychiatric aspects will be attended to carefully, with clinical evaluation, treatment, and care an integral part. The program is individualized, and physicians should write or phone for consideration of their patients to: NIMH, Clinical Center, 2-West Nursing Unit, National Institutes of Health, Bethesda, MD 20014; Mr. Stanley Hirsch or Dr. Walter Sceery will answer (301) 496-5111.

* * * * *

Dr. P. M. Fitzer, whose article "Scanning in the Diagnosis of Hepatic and Splenic Trauma," begins on the next page, very much appreciates the help in its preparation of these: Mrs. Paula Kornegay; Mrs. Peggy Rogers; Mrs. Pat Dmoch, R.T. N. M.T.; the Visual Education Department, MCV, Richmond; the Medical Photography Service, VA Hospital, Hampton. And the management of this journal very much regrets its inability to fit these thanks into the customary place.

* * * * *

CHEST, the journal of circulation, respiration, and related systems, published two Virginia authors in a recent issue. They are Dr. James G. Chandler and Dr. Gerald T. Golden, both of the Department of Surgery, University of Virginia Medical Center, Charlottesville. The title of their article: "Colonic ileus and cecal perforation in patients requiring mechanical ventilatory support." The paper presents observations on seven patients requiring mechanical ventilatory support. In three of these, perforation of the cecum was the first sign of their having colonic ileus. A causal relationship, not noted previously, was suggested by the high incidence of perforation in the series and the common factor of mechanical ventilation. For reprints, address Dr. Chandler.

Scanning in the Diagnosis of Hepatic and Splenic Trauma

P. M. FITZER, M.D.
Newport News, Virginia

Rupture, laceration or hematoma of the liver or spleen may be safely and rapidly demonstrated by radionuclide scanning.

Of belly-injuries nigh all
Which seem to penetrate the wall
Call for the surgeon's intervention
And need immediate attention;
Here we must chiefly concentrate
On those which do not penetrate,
Which oft without an outward sign
Cause visceral lesions quite malign.[1]

THE DIAGNOSIS of hepatic and splenic injuries in the trauma patient with classic physical and plain film findings usually presents little problem. If bleeding is severe there is no time for extensive roentgenographic or laboratory studies. Often, however, the trauma is mild, and the physical findings quite minimal at best. Other injuries may divert attention. The patient may be unconscious. In such circumstances, clinical evaluation of possible hepatic or splenic injuries is difficult. Scanning of the liver and spleen is a safe, accurate, noninvasive, readily available technique for the detection of traumatic rupture, laceration, or hematoma.[2-6] This report describes two cases in which scanning proved helpful in the management of blunt abdominal trauma.

Case Reports

Case 1. A 25-year-old male was admitted with left upper quadrant pain after falling off his motorcycle. Physical examination showed pulse 86, blood pressure 126/70. There was left upper quadrant and left flank tenderness. The spleen could not be palpated. Plain films of the abdomen on admission showed equivocal splenic enlargement. The hematocrit on admission was 39%, and fell only to 36% after 3 days. At the time it was felt clinically that the patient was stable and ready for discharge. A liver and spleen scan was done as a final check. The scan showed splenomegaly with a stellate area of decreased activity, and lacerated spleen was diagnosed (Fig. 1). The liver was normal. Splenectomy was performed. The spleen weighed 410 grams, and measured 17 cm. by 4.5 cm. by 9.5 cm. A stellate laceration with rupture was evident. The patient made an uneventful recovery.

Case 2. A 23-year-old woman was admitted after blunt abdominal trauma sustained in an auto accident. Physical examination showed pulse 100, blood pressure 80/50. There was right upper quadrant guarding and rebound tenderness. No masses were palpated. Plain films of the abdomen and chest were unremarkable. The hematocrit was 34%. Exploratory laparotomy three hours after admission revealed a "large" subcapsular hematoma of the right lobe of the liver; there was also retroperitoneal hematoma on the right. It was elected not to drain the subcapsular hematoma. The patient had a stormy post operative course requiring multiple blood transfusions. A liver and spleen scan four weeks after admsision showed a large area of absent uptake in a markedly enlarged right hepatic lobe with only a peripheral rim of normal uptake (Fig. 2). The spleen was normal. The following day a second laparotomy showed a "huge" subcapsular hematoma of the right hepatic lobe, much larger than at the original operation. The hematoma was drained at this second operation.

FITZER, P. M., M.D., *Director, Laboratory of Nuclear Medicine, Riverside Hospital.*

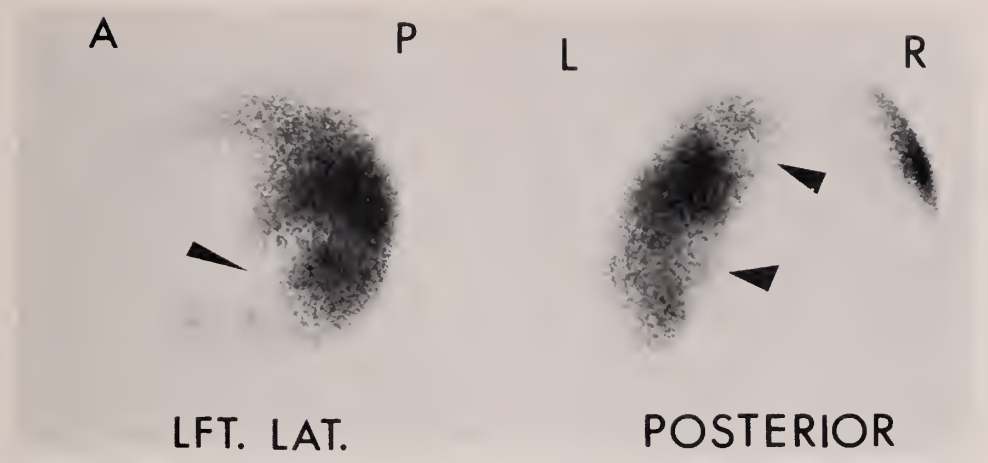


Fig. 1. Stellate area of decreased 99mTc-sulfur colloid uptake is evident on left lateral view of spleen (arrow). The decreased uptake is also seen on posterior view (double arrows).



Fig. 2. Anterior and right lateral views show marked expansion of right hepatic lobe with only a rim of normal 99mTc-sulfur colloid uptake (small arrows). The costal margin is shown by the thin line of decreased uptake (large arrow).

It was felt that continued bleeding into the hematoma was in part responsible for the continued need for blood transfusions. The patient was eventually discharged, and a subsequent liver scan four months later showed resolution of the hematoma (Fig. 3).

Discussion

The radiocolloid of choice for reticuloendothelial imaging of the liver and spleen is 99mTc sulfur colloid. An intravenous dose of 1-3 mCi is used, with imaging commencing 20 minutes after injection. A Nuclear Chicago Pho/Gamma HP scintillation camera with the low energy high resolution collimator is employed and images are recorded on polaroid or 70 mm. film. Standard anterior, lateral, and posterior views of each organ are done, and often oblique views are added. A minimum of 300,000 counts is obtained for each view.

Although others prefer a dual probe rectilinear scanner for liver and spleen imaging,[3] we feel the scintillation camera is the instrument of choice. Imaging is more rapid with the camera, and time is sometimes an important consideration in the evaluation of the trauma patient. Patient manipulation is minimal with the camera, as the camera head may be posi-

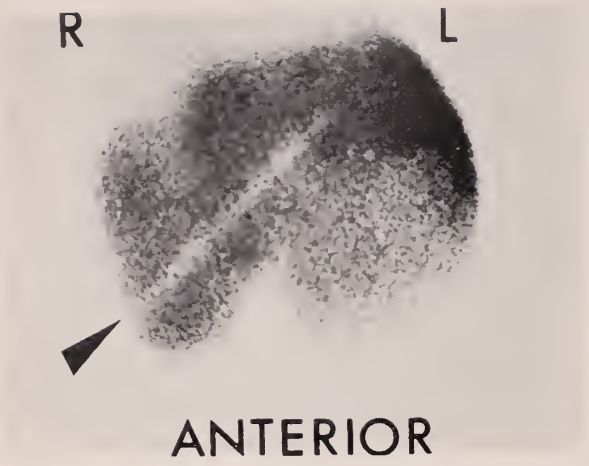


Fig. 3. Anterior view of liver after drainage of hematoma shows normal size right hepatic lobe. Left lobe is prominent. The line of decreased uptake (arrow) indicates right costal margin.

tioned about the supine patient to obtain all the required views. However, a single probe rectilinear scanner can certainly be used, and any laboratory performing thyroid scans is capable of liver and spleen scanning. Colloidal 198 Au has been used for the scan evaluation of liver and spleen injuries,[2] but the radiation dose is now unacceptably high, and the spleen images are poor at best.

In both liver and spleen images, positive findings strongly suggesting rupture, laceration or hematoma include concave, linear, wedge-shaped or stellate defects extending inward from the margin of the organ.[5-6] The two cases above illustrate classic concave and stellate type defects. The importance of multiple views has been stressed for finding small defects.[3,6] Oblique views are also helpful when multiple spleens are present, and when the left lobe of the liver overlies the spleen. Enlargement, patchy uptake, and displacement are far less specific for acute injury. Many conditions may mimic traumatic defects, including cyst, abscess, tumor and infarct, and all the other myriad causes of focal defects in the liver and spleen.[7] Radionuclide angiography has recently been suggested in the diagnosis of splenic rupture for demonstrating subtle signs of downward displacement of the spleen by hematoma.[8] However, the spleen may normally be somewhat mobile or slightly displaced,[9-11] and the usefulness of radionuclide angiography remains to be proven. Rupture of the spleen may be delayed,[12] and delayed splenic rupture demonstrated by serial scans has been reported.[13] Serial scans may also be used to follow resolution of hematomas as shown by Case 2 above.

In the few series available, there are very few false negative scans in patients with documented liver or spleen trauma.[4,6] As noted above, false positive results may be more frequent. Angiography has been advocated for the evaluation of liver and spleen injuries,[14-15] and, at least in the case of splenic injuries, is probably slightly more accurate.[6] However, in the largest series to date, "there was no case in which angiography provided a correct definitive diagnosis when the radionuclide image was incorrect".[6] Further, angiography involves some minimal although definite morbidity, often compounded in the severely ill patient with multiple injuries. Further, many hospitals have limited angiographic capabilities. The radiation dose received from the fluoroscopy and multiple radiographic exposures of angiography must also be considered. As noted above, scanning is safe, rapid, non-invasive and widely available. The scan also tends to be easier to interpret and less equivocal than the angiogram.[6] Liver and spleen scanning should find wide use in the evaluation of blunt abdominal trauma.

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(Continued from page 22, "The Father Who Was Not a Father," by M. J. V. Smith, M.D.)

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The Rehabilitation of Adolescent Drug Abusers: A Comprehensive Approach

GEORGE M. BRIGHT, M.D.
Richmond, Virginia

Drug abuse among adolescents, of grave concern for a decade, is dealt with in a model program designed to identify root causes of the problem and rehabilitate according to individual need.

THE ADOLESCENT Medicine Program is a combined inpatient and outpatient service in the department of Pediatrics. The age group served ranges from 12 to 21 years. The program operates on the assumption that the medical and social needs of this age group are generally poorly understood. Comprehensive services for a wide variety of complaints are offered to patients from all socioeconomic levels. Treatment of the individual is achieved by a team of professionals and is based on interest in the patient as a whole person.

Visits are by appointment and are long enough to avoid the haste and preoccupation often found in many busy clinics. At least an hour is allowed for each patient and his or her parents. At the initial visit the patient and parents are seen separately for a complete medical-social history along with a complete physical examination. Followup visits are scheduled for as long as one hour, depending on the patient's needs as related to the chief complaint.

On subsequent visits the patient is encouraged to take responsibility for his own appointments and treatment. An understanding is established with the patient during the first visit: information is kept strictly confidential with the expectation that the patient will be totally honest with the staff and consistent in performance to the extent possible.

The program stresses the individual's ability to perform in specific areas in his environment. These performance areas are divided into five categories: medical, social, emotional, educational and vocational. How well the individual performs in these areas will have great influence upon his self-concept, that is, the theoretical combination of body image and self-image. Although the growth and development of the self-concept begins at birth and continues throughout childhood, the body-image becomes particularly important as a component of self-concept during adolescence. Indeed, the body is of paramount concern to all adolescents.

Particular attention is given to evaluation of the patient's self-image (Who am I? What am I? Where am I going?) as it influences and is influenced by his performance in these five critical areas. Ability to perform satisfactorily in these areas will largely determine the success of the adolescent in coping with his transitional state of puberty and with the instabilities of his environment as he grows and develops.

Our experience of the past four years indicates that few chronic drug abusers have had sufficient success in one or more of these areas to enable them to cope with themselves and the demands of their environment. Illicit use of drugs serves, they feel, to give them the ability to perform and, in many cases, to reduce the requirements of the environment by making them less aware of these demands.

The approach to rehabilitation involves close examination of these areas to determine the individual's strength and weaknesses. Thus, evaluation of the patient's performance in these areas provides the framework needed to identify the causes of the drug abuse and to

outline a therapeutic program which builds upon the patient's assets.

Methods and Materials

Information regarding the major performance areas is obtained at the time of the initial interview from parents and/or patient by staff members. This information is recorded on standard history and physical forms. A social intake form is completed by the patient with the help of a staff member. Let use look more closely at these critical areas.

A complete medical history, including a review of systems from birth, is obtained by the examining physician. The medical history gives information concerning growth and development of the individual from birth to the present. All major systems are reviewed but close attention is directed to a past history of congenital defects, prolonged or chronic illness, periods of separation from parents, family constellation problems and the child-parent response to these problems.

History regarding the appearance of the secondary sex characteristics is important to the understanding of the patient's feelings about his body image. A striking feature of our drug-abusing population among males is an immature physical appearance. There seems to be a definite correlation between physiologically delayed puberty and negative feelings about body image contributing to drug abuse.

A complete review of drugs used, with concentration on frequency of use and route of administration, helps distinguish between habituation and addiction. These findings help us to decide whether care on an outpatient or inpatient basis is indicated.

The physical examination performed includes an audiogram and visual screen, using an accurately calibrated audiometer and standardized Titmus eye test for adolescents and adults. Fresh or healed veni-puncture marks traceable to heroin and barbiturate addiction are frequently found.

Laboratory studies include routine vital signs, urine screen for barbiturates, quinine, morphine, codeine, cocaine, methadone, amphetamines and other drugs which are identifiable with the specific screening method used by this program. Other studies considered important are: complete blood count including hemoglobin, white blood cell count and differential, sickle cell preparation on all black patients, sequential multiple analysis-12, Tine test, serology test for syphilis and fluorescent treponema anti-body, and a pelvic examination on all females, including Pap smear and cervical cultures for gonorrhea.

School records are requested which include standardized test results and teachers' comments regarding social interaction and vocational interests and aptitudes. A complete history of school performance from kindergarten to the highest grade achieved gives a good indication of the patient's ability to compete and achieve success in a very competitive educational atmosphere. We consider education to be the "primary job" of the school age adolescent. If learning disabilities enter into the patient's adjustment, special testing is done to identify the type and degree of disability. We see a distinct correlation between school failure, learning disabilities, and drug abuse and juvenile delinquency. The vocational choice of many adolescents is reflected in history of success in areas other than academic endeavors, such as trade skills, i.e., mechanical work, drama, athletics, art and music. Each patient receives either the Kuder or Strong Vocational Interest Test at the clinic or is referred to the Virginia State Employment Commission for the General Aptitude Test Battery (GATB) which gives more indepth information as to interests, skills and possibilities for future planning with the patient.

Ability to interact socially is evaluated by observation of the patient with parents, history of peer group activities and interaction, general interests and how the patient gets along with other authority figures and siblings. The therapeutic team is then able to plan effectively to assist the development of specific social skills in areas which have been lacking.

The adolescent's ability to deal effectively with authority figures and to tolerate delayed gratification is reflected in the history of his

emotional response to life's stressful situations. The Minnesota Multi-Phasic Personality Inventory (MMPI) and/or additional individual psychological evaluation is administered to each patient whose behavior reflects a need for more indepth information.

Discussion

Once the history, physical and supporting data are assembled, the professional team begins the rehabilitative process. The team consists of two physicians, two vocational counselors, the nurse coordinator and other nurses, the social worker, the educational consultant and the medical librarian. Psychiatrists and clinical psychologists are called for consultation in many cases. The professional team first determines the type or types of programs best suited to the unique needs of the individual.

A striking absence of consistent guidance is common to 70% to 80% of our patient population. A major thrust of the team approach to rehabilitation is directed toward providing a structured program that will permit maximum growth and development of self-concept from assets identified in the damaged or inadequate formulations he brings into the therapeutic program. When identified, this form of treatment may be compared with the time and dose response of a prescribed medication which elicits a desired effect in treating specific disease. The malleability of the adolescent is an advantage in helping him to adapt to a newly imposed framework which is structured, consistent and fair. The choice of alternatives within that framework allows significant chances for success, thereby changing a negative lifestyle to one that is positive in terms of meeting the needs of the individual as required by his environment.

The medical aspects of drug abuse involve treatment of the physiological response to the drug itself, contaminants or additives. From 1971 to 1973 our most common medical emergency involved heroin addiction. Nalaxone® is used for overdose problems, and methadone hydrochloride is used for addiction detoxification or short term maintenance followed by slow detoxification. The guidelines for the methadone treatment program are in accord with those of the Federal Drug Administration and Bureau of Narcotics and Dangerous Drugs and are carefully followed.

All medical admissions are cared for on the adolescent medical ward, a 14-bed unit separate from the pediatric and adult age groups. Barbiturate addicts are admitted to the ward unit for medical detoxification. While in the hospital, they participate in a behavioral token program designed to make them aware of those negative behavioral patterns that can best be modified through constructive alternatives with appropriate rewards for their daily activities. For example, if the patient gets up on time, makes his bed and attends prescribed activities, he receives tokens which are exchanged for privileges, such as having visitors.

The nurse is responsible for coordinating all medical services to the patient. She screens patients in initial interviews, obtains urines for drug screening and verifies addiction histories. She works closely with the other nurses to complete the medical workup. She consults with other medical departments when indicated.

Our nurse coordinator maintains accurate and uptodate medical records which provide the staff with a complete readily available picture of the patient's medical history. Weekly, monthly and quarterly statistic sheets compiled by each staff member for the nurse enhance the flow of information concerning the progress of the patient.

Infants born to mothers who are being maintained on methadone hydrochloride are cared for in the pediatric newborn nursery with neonatal and maternal care in the adolescent outpatient service.

The social worker assists most applicants with the social intake history at the initial interview. He often makes evening visits to the home to get a better understanding of family relationships. When indicated, he conducts family discussions and provides counsel to help solve crises within the family.

During this past year, the social worker led an after-school motivation group to encourage

and direct patients in their pursuits of work, school and getting along at home and with authority figures.

Followup care is the responsibility of the social worker, and he is expected to refer patients to other sources of help in the community when the program at the Adolescent Medicine Clinic is no longer appropriate.

The vocational counselors perform a major role in helping the patient to examine realistically his ability to use potential and incompletely developed skills. Our counselors help each patient to acquire skills in filling out school and job application forms before being referred for a fulltime or partime job.

Job placement is difficult even with trained personnel in today's tight job market. Counselors administer and interpret vocational interests and recommend patients for placement accordingly. The patient is assessed in all performance areas to determine his ability to cope with the challenges which a proposed job or school setting might bring.

Educational information obtained from the school records and special tests performed by the educational consultant in the clinic assist in making decisions regarding referral. Frequently, students who have talent in art, music, athletics and drama are prevented from participation because of poor academic grades, poor attitude and attendance records. This situation prompts a visit to the school by the vocational and educational counselors and/or nurse. They consult with school personnel to try to effect changes in schedule or set up special programs to allow the patient to participate in areas where these skills can be developed. Success achieved in specific areas usually results in improved attendance and academic performance.

The majority of new patients have histories of school difficulties which have existed for a number of years. A careful review of academic records is made by the clinic's educational consultant. Supplementary tests are administered in reading, spelling, and mathematics, and accurate assessments are made to help determine the cause of the learning problem. An appropriate remedial program is then devised for the individual. This educational prescription is based on the patient's ability to perform socially and emotionally as well as educationally in that environment.

Educational skills are basic to coping with almost every facet of society's demands for performance. Without these skills, overwhelming feelings of frustration and failure result in emotional immaturity.

School and court referrals for drug abuse are frequently associated with learning problems as the basic cause of antisocial behavior. Remediation is accomplished through one of two channels: individual tutorial work in the clinic or on the ward with the educational consultant, or a special inschool program devised through consultation with school officials and resource teachers. Methods of remediation vary, but in the language area in which help is most frequently needed, the Orton-Gillingham phonetic program is utilized.

A scholarship fund for adolescent patients has provided financial assistance to those who are unable to pay for special school programs which are not covered by grants or through the Virginia Department of Education.

To attack these basic problems, the total rehabilitative services are herein described. There is also an opportunity for group participation in the evening in a home setting, away from the clinic. On Saturdays, a group of patients who have talent and interest in art, meets with an art educator to help them develop self-awareness through art.

The Adolescent Clinic works closely with the Juvenile and Domestic Court judges and probation officers and with lawyers in the Virginia Criminal Justice systems. Comprehensive and constructive rehabilitation plans for patients in litigation are presented to the courts in lieu of incarceration for criminal offenses related to drug abuse. Probation to the Adolescent Program, with all of its rehabilitative services, is a frequent decision in these court cases. Progress reports and weekly meetings with probation officers enhance communication and cooperation with the Criminal Justice system. We feel that our alternatives to incarceration offer constructive steps toward

rehabilitation through growth of the adolescent self-concept.

The clinical staff participates in continuing postgraduate education programs at the schools of Medicine, Nursing, Social Work and Education at Virginia Commonwealth University.

Lectures and seminars are conducted with community organizations and agencies throughout the state to provide information concerning the dynamics of drug abuse. These programs serve to educate the community at large and assist organizations to develop similar rehabilitative programs.

Summary

We believe that the Adolescent Medicine Program offers its drug abusing population a comprehensive program of rehabilitation, sufficiently broad in service delivery areas to enable the individual's self-concept to grow and develop. The response of the community, in its cooperation with the professional clinic staff through the courts, schools, vocational and social agencies, results in a change to a positive life style and a more hopeful future for the adolescent.

Department of Pediatrics
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* * * * *

Henry George White, Jr., M.D., has assumed the presidency of the Northern Virginia Medical Society. Serving with him are George L. Sheppard, Jr., M.D., Vice-President, and Gary W. Wake, M.D., Secretary-Treasurer.

* * * * *

1976 brings Thomas M. Fulcher, M.D., to the presidency of the Fairfax County Medical Society. His associate officers are Richard L. Fields, M.D., Vice-President; Leon I. Block, M.D., Secretary; Ira D. Godwin, M.D., Treasurer. Eugene O.S. Stevenson, M.D., is the President-Elect.

* * * * *

Female voice on the wire at the Arlington County Medical Society is Mrs. Patricia C. Murray, new Executive Secretary.

COMMONWEALTH PSYCHIATRIC CENTER

Exclusively For Children and Adolescents--
A new, completely modern 66-bed hospital is now open for patient referrals

■ Work has recently been completed on this new hospital, specifically designed for the treatment of the emotionally disturbed. In addition to the hospital itself, the Center is moving ahead with construction of a gymnasium and swimming pool to provide its patients with the very best of private institutional facilities in the Mid-Atlantic Region.

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Brochure on Request



Richmond Times-Dispatch

Sunday, July 15, 1973

New Hospital Planned

Plans to build a 66-bed hospital building and to renovate existing facilities have been announced by the Commonwealth Psychiatric Center here

Work on the new hospital on the center's grounds at 3001 Fifth Ave is scheduled to start within a few weeks Completion of the project is expected in late 1974

Dr William M Lordi, director of the center said the cost of the project including development costs renovation site work and the actual construction will be more than $1 million

Lordi said work on renovating the present facilities has already started

He said three buildings—the Lor Berg Family Guidance Clinic Janus Hall and Jacob Silverburg Academy—are to be improved The renovation will include interior improvements throughout all three moderization of kitchen and dining rooms and installation of a gym a workshop and an activity room

The new hospital building will be a two-story structure with 33 semi-private rooms six lounges seven offices for doctors an examining room two main nursing stations and a complete dining room

Plans for the expansion have been approved by the Capital Area Comprehensive Health Planning Council Lordi said The council is the official health planning authority in the Richmond area

The expansion is being made to meet a shortage of child and adolescent mental health programs in the Richmond area Lordi said

Currently the center has an 18-bed hospital facility

Lordi said adolescent admissions to mental health centers have almost doubled in the United States in the last 10 years

Recent surveys have indicated that 10 per cent of all schoolaged children are in need of psychiatric help Lordi said He said half of these were serious enough to require inhospital care

The Commonwealth Psychiatric Center is the only one in Virginia devoted almost entirely to child and adolescent mental problems The center primarily handles children aged 5 to 18 but also cares for adults as outpatients

Architects for the new hospital building are Lockman Associates of Washington

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Adolescents in Public Care in Virginia:
How to Achieve Maximum Benefits from Minimal Facilities

ANDRE P. DERDEYN, M.D.
CAROL PLUNKETT, M.S.W.
Charlottesville, Virginia

THIS IS A DISCUSSION regarding aspects of the care of adolescents who are entrusted to the Welfare Department and the Department of Corrections in the state of Virginia. First, we will discuss the findings of the Joint Commission on the Mental Health of Children, which addressed the problem of adolescents in public care on a national level; then the findings of the Hirst Commission (The Commonwealth of Virginia Commission on Mental, Indigent, and Geriatric Patients) relevant to adolescents will be discussed. Existing facilities of the state of Virginia will be briefly described and an important hiatus in the system of care will be described. This will be followed by a discussion of the unique contributions which workers of departments of public welfare can and do make, to enhance the constructive potential of the existing institutions.

Joint Commission's Report

In the report of the Joint Commission on the Mental Health of Children, which came out in 1970, it was reported that in 1966 there were more than 27,000 children under age 18 in state and county mental hospitals, and the majority were over 10 and male.

The Joint Commission felt that the major unmet need in the mental health of children was that of improved institutional care for the adolescent. They reported that adolescent admissions to state hospitals increased 150% between 1960 and 1970. The Commission also recognized that intensive residential treatment is only a part of the approach to seriously disturbed adolescents, due to the great numbers of children involved and the paucity of institutions to care for them. The Commission estimated very conservatively that one-half of one percent of children are seriously disturbed. In Virginia alone there are 1.7 million persons under 18 and one-half of one percent of them amounts to 8,500 seriously disturbed children. The Commission suggested experimenting with alternatives to the usual very expensive residential care for disturbed children. They felt one could differentiate between those children with the most severe disorders for whom intensive psychiatric treatment is essential, and those who are more likely to respond well to a more generalized approach. They suggested the use of mental health specialists as consultants and the expanded use of paraprofessionals to deal with those children who are apt to respond to the more generalized approach.

With regard to the juvenile offender, the Joint Commission estimated that 11 percent of all children in the U. S. will reach juvenile court by the time they are 19. In 1965, statistics showed that persons 18 and under accounted for 24% of forcible rape, 52% of burglary, 45% of larceny, and 61% of auto theft. The Commission emphasized that delinquency is a symptom and that the psychological causes for delinquent behavior vary greatly. The report also stated that many young people suffering from emotional disturbance or mental illness were being labeled as delinquent and placed in institutions not offering treatment.

Doctor Derdeyn is the Training Director of the Division of Child and Adolescent Psychiatry, University of Virginia School of Medicine, Charlottesville.

Mrs. Plunkett is Supervisor of the Family and Children's Services Division, Charlottesville Department of Public Welfare.

Presented in part at the Residential Care Workshop, Charlottesville, April 16, 1975.

The Hirst Commission

The Hirst Commission, otherwise known as the Commonwealth of Virginia Commission on Mental, Indigent, and Geriatric Patients, was created by the Virginia General Assembly in 1968 and made its report in 1971. The Commission addressed itself to the need for more help for our adolescents and recommended increased funds for community services and for residential facilities for emotionally disturbed adolescents.

The Hirst Commission quoted the then existing division of Youth Services of the Department of Welfare and Institutions as reporting that from 30 to 50% of their training school population is so seriously disturbed that intensive prolonged treatment is indicated but unavailable.

A major shortcoming recognized by the Hirst Commission is the lack of longterm treatment in existing facilities. They reported that the average stay at Virginia Treatment Center is five months and that the statute limit is one year. Similarly, the learning centers (formerly known as training schools) are crowded and the length of stay is a relatively short average of six to eight months. The Commission reported that neither the state's hospitals nor its learning centers has the capability for caring for and rehabilitating severely emotionally disturbed children, except for the unit at Eastern State Hospital and, more recently, the one developed at Western State Hospital.

Adolescent Needs vs. Facilities

In Virginia the major institutional facilities for adolescents are the learning centers, of which four are devoted to the care of the adolescent age group. Other than individual foster homes taking in adolescents, there are 41 group care homes. There are also a small number of private boarding schools offering special educational services for which the State Department of Education may provide up to $5,000 per year for the education of a child.

Probably the bulk of adolescents who require placement, those with mild to moderate behavior or emotional problems, can be adequately served by existing facilities. The more severely disturbed adolescents, or those who are transiently very upset, find their way to inpatient treatment facilities. However, very few of these can be considered as a separate group for very long, for most are soon discharged. Similarly, most of the more serious offenders served by the training schools are discharged and returned home or to other placement facilities. Both of these groups and some of the adolescents with significant emotional or behavior problems who are not hospitalized or incarcerated, may require more than the usual placement offers.

There remains a need for a new type of institution where a generalized approach as advocated by the Joint Commission could be utilized. There is a group of adolescents who for a variety of reasons cannot or should not be maintained at home, and for whom local psychiatric and other services and group or probation homes are not likely to be adequate. These adolescents do not require intensive treatment but might require extended residential placement. Their needs could be adequately served by small educationally oriented institutions where structure and discipline would be maintained, group activities stressed, and counseling, if not formal psychotherapy, would be available. Such institutions could be located close to mental health facilities where consultation and direct treatment would be available. Cost would be considerably less than that of bona fide residential treatment, although many of the principles found so useful in residential treatment could be utilized, such as a system of coordination and communication among the staff to deal immediately with problems.

It appears, however, that due to the financial problems facing our state and nation, added to the general reluctance to provide for such services, the idea of developing new institutions is quite unrealistic. So, if we cannot develop new institutions, then we might better develop the institutions that we have, and potentiate their benefits to these children. We do not want to minimize the fact, however, that we still need more facilities, both in terms

of long-term psychiatric treatment and long-term placements that can tolerate adolescents who present some of the more difficult behavior and emotional problems.

Maximizing Agency Benefits

The Role of the Psychiatrist: The central role of the psychiatrist is in assisting in the assessment and treatment planning of children and their families. This is the type of involvement most usually thought of for the psychiatric consultant regarding adolescents in public care. However, another role deserves emphasis. This is consultation to staffs of group homes and learning centers. Many of the persons working in these institutions, especially the persons having the most contact with the children, are lay persons with varying degrees of education in the field and little or no supervised experience. One of the requisites for being helpful to people with emotional difficulties is to be able to accept the person and not to take personally their behavior, not to respond in an angry fashion when our moral standards are derogated or threatened, or to otherwise become involved in personal issues which can interfere with one's helpfulness. This aspect of training is teachable without requiring the learning of great amounts of theory or technical expertise. Generally, the two extremes in which people tend to respond are (1) to be punitive when one's personal attitudes and defenses are threatened by an adolescent's poor sexual or aggressive impulse control, and (2) to become so involved with the fact that many of these children have had very limited opportunities in life, and that they are indeed symptoms of society's problems, that the worker tends to be involved with pity and political action for social justice, but has difficulty in helping the adolescent learn how to take responsibility for himself. Individual or small group supervision can be very useful in helping people put their personal reactions in perspective and deal with the adolescent more purely on the basis of one's understanding of his needs.

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The Role of the Public Welfare Worker: The role of workers of departments of public welfare regarding adolescents in public care is much broader and encompasses many more therapeutic principles than is generally appreciated.

The positive effects of any placement can be potentiated by careful preparation of the adolescent, which entails the involvement of the child with the placement planning as much as is possible. With this kind of preparation, the constructive effect of any placement can be maximized. The potentially destructive effects resulting from the feelings of the adolescent and his family that they are simply being manipulated by the whims of those in power, or that placement is the wage of failure and evidence of rejection by society, can be avoided.

In situations where placement is necessary, there are several features identifiable in the approach of the welfare department worker to an adolescent and his family. The first and most important feature is to present the plan of placement to the child and his family in terms of this being another step in the treatment continuum and not "the end of the road." The second step calls for the setting up of a meeting between the child, his parents, the counselor of the institution in which he is to be placed, and the welfare department worker. In this meeting a "placement contract" is developed. Frequently, the details of this contract are written by the welfare department worker following the meeting and sent in a letter to the other three parties. The placement contract focuses on concrete identification with the child, and often the parents, of the problem areas to be focused upon. Examples of such contracts will be included in the two case descriptions which follow. The parents often identify the problem areas they wish to work on as (1) making rules for the children, (2) more consistently maintaining the rules, and (3) following through on professional counseling for themselves. The parents' contract usually includes planned visits with the child.

The institution counselor's portion of the contract usually includes setting up programs to help the child alter the behaviors they have chosen to enhance or to diminish. The counselor helps the child look at his successes and failures through immediate feedback. But most importantly, he shows the child that he remains interested in him through difficult as well as good times. The counselor also keeps the welfare worker informed of the child's progress.

The welfare department worker has a major responsibility outlined in this contract. First, he remains in contact with the child and his family through letters and regular visits. The welfare worker has an important function in maintaining the child's link to the community. The primary focus of this community contact is with the child's family. The worker continues to work with the family with regard to their goals. Another way the child's link to the community is maintained is by the worker's carrying seemingly inconsequential news about the activities of friends and school. In addition, the worker reports on more important issues, such as the conference with the vice-principal to begin planning for the child's return to the school system.

The Charlottesville Experience

Welfare departments are finding that more of the children being committed for placement are adolescents. For example, 22 of the 40 children committed to the Charlottesville Welfare Department from January 1, 1973, through March of 1975 were adolescents. Of these, 21 had been or were about to go before the Juvenile Court. Subsequent evaluations by psychologists and psychiatrists showed that 13 of those adolescents had significant emotional problems.

The high incidence of psychiatric problems comes as no surprise. Children who reach the point of removal from their natural homes, for whatever reason, are a high risk group. Despite the problems these children presented, and despite limitations of the institutions to which they were sent, 10 of these 13 teenagers appear to have benefited from placement. The types of placements utilized for these 13 teen-

agers included inpatient psychiatric settings, child care institutions, group homes, foster homes, and learning centers.

Ideally, prior to planning a treatment program and arranging the placement contract meeting, the worker would have mental health consultation regarding the child and his family. The dynamics underlying the child's behavior as well as that of his family should be understood to facilitate effective planning. This knowledge helps to guide the approach of the worker and aids in developing programs that most suit the child's needs and the available resources. We will now proceed with two case examples.

Placement in a Group Home: Fourteen-year-old Sharon was referred to the Welfare Department by the local mental health clinic, as the clinic felt Sharon would be unable to work out many of her emotional problems while remaining at home. Behavioral manifestations included being unable to develop and maintain friendships, being unable to tolerate direction from parents or teachers, and fighting at school and elsewhere.

The placement contract was developed at a meeting between Sharon, her parents, her group home counselor, and her welfare department case worker, prior to her placement at a group home. Sharon's goal was to return home to her parents. The contract outlined the problems Sharon had agreed to work on. These problems included (1) learning to control her temper, (2) learning to maintain relationships with people her own age, and (3) learning to assume responsibility and to tolerate persons in authority.

In addition, the contract outlined those areas Sharon's mother was going to work on at home. The worker began to discuss with Sharon's mother basic parenting issues, such as the need for increased consistency and clarity of her expectations regarding Sharon. After Sharon's weekend visits home to her mother, the events of the weekend were reviewed by the worker and Sharon's mother. Effective

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parenting behaviors were reinforced, and areas of difficulty were subjected to further scrutiny and planning.

After a year in this group placement, Sharon speaks enthusiastically of the considerable gains she has made in learning to control her temper and in finding other ways to express her feelings. Peer relationships are coming a little slower for her. She is no longer so aggressive in her actions, but still tends to try to manipulate others by "tattling," telling stories, or making one person a friend for the day to the exclusion of all others. She is much more accepting of direction from adults. Her statement of her recent situation is "much, much better, but I still have to learn how to treat my friends better."

The worker's role in maintaining the tie between home and the adolescent through regular and frequent visits with the child and family is a sustaining force for this child, who very much looks forward to returning home.

These same principles can be carried over to the learning center placements.

Placement in a Learning Center: Sixteen-year-old Don was committed to the State Department of Corrections because of his extreme aggressiveness. After Don's placement in the learning center, there was a conference with Don, his counselor at the center, and his welfare worker. Due to the parents' significant emotional problems, and after unsuccessful attempts to work with them, Don's return to his home was not being considered as an essential goal in his treatment planning, and his parents were not parties to the conference. Details of the contract were relayed to the parents, however. In this meeting Don's goals developed as his need to (1) learn to control his temper and find other more productive ways to vent his feelings, (2) develop greater ability to cooperate and share with other boys his age, and (3) decide what he wanted to do in terms of preparation for his future. Being committed to the learning center was explained in terms of his need to be in a place which would offer controls and structure until he could slowly relearn self-control. The welfare worker's contract included bimonthly visits with Don and work with his mother to support her in her care of the other children and to encourage at least written communications with Don.

After eight months of state care, Don has started to learn to talk about his feelings and problems, in contrast to his earlier pattern of reacting to stress and anxiety with indiscriminate aggression. He is beginning to make decisions about how he will handle his parents in terms of their problems, if he does decide to return home. He has also developed some friendships for the first time, and for the last two months has had none of the violent outbursts which were so characteristic of him. He is now participating in the planning for the next phase of his life.

Conclusion

It is apparent that our facilities could better match the needs of many of our adolescents. However, with the help of mental health consultation, the determined outreach and liaison work which can be performed by workers of departments of public welfare can greatly enhance for the adolescent the helpfulness of any of the existing institutions. With the kind of planning and follow-through which can be done, placement can be made a very constructive experience for some of these adolescents having significant behavior and emotional problems.

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Charlottesville, Virginia 22901

* * * * *

New officers of the Virginia Dermatological Society are B. Voss Neal, M.D., Newport News, President; Francis H. McMullan, M.D., Richmond, Vice-President; Kenneth E. Greer, M.D., Charlottesville, Secretary-Treasurer.

* * * * *

Dr. Delos Boyer is the new president of the Danville-Pittsylvania Academy of Medicine. Other officers to serve with him: Dr. Hugh Willis and Dr. John J. Neal, Jr., Vice-Presidents; Dr. Michael A. Gangloff, Secretary-Treasurer; Dr. Edwin Harvie and Dr. Joseph Milan, delegates to the Medical Society of Virginia.

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1976 CONTINUING EDUCATION SYMPOSIUM
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NORFOLK, VIRGINIA

This symposium will examine recent and practical advances in *oncology, cardiology, gastrointestinal diseases,* and *trauma.* It has been designed for the practicing physician and will emphasize changes and advancements which have occurred in recent years, and which have application in everyday practice. Norfolk General, and Leigh Memorial Divisions of Medical Center Hospitals,in conjunction with Eastern Virginia Medical School-Graduate School of Medicine, have joined together to plan a stimulating and effective program. The four major sessions will feature an impressive roster of guest speakers. Primary care physicians and specialists will find these sessions of special significance.

This program is acceptable for 11 elective hours by the American Academy of Family Physicians.

- Symposium will take place during the famed Azalea Festival Week.
- Dedication and tour of the new MCH Radiation Therapy Center.
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- Gala reception and dinner, evening entertainment.

I am interested in receiving further information about the 1976 MCH/EVMS Medical Symposium. Please send to:

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Mail to: 1976 Medical Symposium
Medical Center Hospitals
600 Gresham Drive
Norfolk, Virginia
23507

Calendar of Medical Events, 1976

January

Medico Legal Workshop—Sponsored by Office of the Chief Medical Examiner, MCV Department of Legal Medicine, Virginia Society for Pathology, Inc. and Virginia Academy of Family Physicians—Tidewater Memorial Hospital, Tappahannock—January 29.

Adolescent Medicine for Practicing Physicians—Sponsored by Department of Pediatrics, MCV—Richmond—January 29.

72nd Annual Congress on Medical Education—Presented by Council on Medical Education, AMA—Palmer House, Chicago—January 30-February 1.

February

Symposium on Recent Advances in Bacterial and Viral Gastroenteritis—Sponsored by Department of Microbiology, MCV—Richmond—February 5-6.

Recent Advances in Genetics—Sponsored by Pediatric Continuing Education Program, University of Virginia School of Medicine—McKim Conference Room, Charlottesville—February 11.

Virginia Regional Meeting—American College of Physicians with Virginia Society of Internal Medicine—Charlottesville—February 14.

Pediatric Hematology—Oncology for the Practicing Physician—Sponsored by Department of Pediatrics, MCV—Richmond—February 18.

The Challenges of Ambulatory Care of Tuberculosis (Koch Centennial Symposium)—Sponsored by the Baltimore City Health Department—Hilton Hotel, Baltimore—February 20-21. (*See page 5 for details.*)

"What's Wrong with My Eyes?"—Sponsored by the Department of Ophthalmology cooperating with the Departments of Family Practice and Continuing Education, Eastern Virginia Medical School, Norfolk—February 28.

Radiology of the G. U. Tract—Sponsored by Department of Radiology, MCV—Williamsburg—February 29-March 4.

March

Law Institute on Hospitals and Medicine—Sponsored by Department of Legal Medicine and Department of Hospital and Health Administration, MCV—Larrick Student Center, MCV, Richmond—March 5.

Recent Advances in Neonatology—Sponsored by Pediatric Continuing Education Program, University of Virginia School of Medicine—McKim Conference Room, Charlottesville—March 11.

Neonatology for the Practicing Physician—Sponsored by Department of Pediatrics, MCV—Richmond—March 18.

29th Annual Stoneburner Lecture Series—Neurology for Primary Care Physicians—Sponsored by Department of Neurology, MCV—Richmond—March 25-26.

April

Pediatric Cardiology for the Practicing Physician—Sponsored by Department of Pediatrics—Pediatric Cardiology, MCV—Richmond—April 1.

International Surgical Conference—Sponsored by Department of Surgery with Department of Continuing Education, MCV—Williamsburg—April 4-11.

Recent Advances in Neurology—Sponsored by Pediatric Continuing Education Program, University of Virginia School of Medicine—McKim Conference Center, Charlottesville—April 8.

Practical Advances in Medicine—MCH 9th Annual Symposium—Sponsored by Medical Center Hospitals and Eastern Virginia Medical School—Omni International Hotel, Norfolk—April 26-27.

Medico Legal Workshop—Sponsored by Office of Chief Medical Examiner, MCV Department of Legal Medicine, Virginia Society for Pathology, Inc. and Virginia Academy of Family Physicians—Virginia Baptist Hospital, Lynchburg—April 22.

The Medical Society of Virginia . . . .

Minutes of Council
The Annual Meeting, Roanoke

A meeting of the Council of The Medical Society of Virginia was held at the Hotel Roanoke on Thursday, October 23.

Members Present: Dr. William R. Hill, Dr. Raymond S. Brown, Dr. John A. Martin, Dr. Anthony J. Munoz, Dr. Harold L. Williams, Dr. Charles E. Davis, Jr., Dr. Carrington Williams, Jr., Dr. Gordon G. Birdsong, Dr. Girard V. Thompson, Sr., Dr. H. C. Alexander, III, Dr. George M. Nipe, Dr. Harry C. Kuykendall, Dr. James Hal Smith and Dr. W. Leonard Weyl.

Others Present: Dr. K. K. Wallace, Jr., Vice-Speaker; Dr. William Stewart Burton, Dr. Gervas S. Taylor, Jr., Dr. Henry M. Snell, Dr. Nicholas G. Colletti and Dr. Richard L. Fields, Vice-Councilors; Dr. M. J. Olichney representing Vice-Councilor Harry L. Westfall, Jr., M.D.; Dr. William S. Hotchkiss, Dr. Michael A. Puzak and Dr. F. Ashton Carmines, AMA Delegates; Dr. John A. Martin and Dr. Carl E. Stark, Alternate AMA Delegates; Mrs. Randolph H. Hoge, President, Woman's Auxiliary to The Medical Society of Virginia; Mr. Robert G. Stuart, Executive Secretary, VaMPAC; Dr. John R. Davis, representing the Medical & Chirurgical Faculty of the State of Maryland; Mr. James L. McCoy, representing the MCV Student Medical Society.

Financial Report and Budget

Dr. Michael Puzak, Chairman of the Finance Committee, reported that the Society had once again enjoyed an excellent year financially. He stated that, in the opinion of his Committee, the Society's investment program was unusually sound and productive. As a result, the Society was able once again to report an excess of income over expenses.

Dr. Puzak called attention to the fact that some question had been raised about the number of official Society representatives sent to meetings of the American Medical Association. The feeling exists that a review of this particular matter might be in order in the hope that a substantial saving might be realized.

Council was also asked to consider the advisability of adopting a definite policy concerning financial commitments for visiting Presidents and other distinguished guests. It seems that a number of states have elected to assume the expense of their own fraternal delegates and that The Medical Society of Virginia might look into the situation with next year's annual meeting in mind. It was the consensus that these matters deserve more detailed consideration at a future meeting of Council.

Dr. Puzak presented a balanced budget for fiscal 1975-76 and indicated that no dues increase appeared necessary at this time.

A motion approving the budget and referring it to the House of Delegates for further consideration was seconded and adopted.

Professional Liability

Council was reminded that consideration of the proposal of the Physicians Underwriting Company, Inc., had been postponed until such time as Mr. Miller had an opportunity to review that company's subscription contract and make such comments as he might believe advisable.

A letter from Mr. Miller commenting on the subscribers agreement was then read. Certain points were stressed—particularly those having to do with control. It was learned that under a reciprocal insurance exchange effective power is given to the agent or attorney in fact. There is, however, an advisory committee which normally will have a voice in such matters as general policy direction, review and evaluation, etc. The committee does not have the power of a Board and neither would it have the increasing responsibility.

Also of interest were Mr. Miller's comments on the power of the attorney in fact to terminate an agreement and cancel all contracts without notice.

After considerable discussion during which hope was expressed that any obvious weaknesses in the subscribers' agreement might be corrected, Council determined that no action was indicated since the overall subject would be considered by the House.

VaMPAC

During its meeting on October 2, Council postponed the election of a Board of Directors for VaMPAC until such time as additional information could be made available. Since the information was now available, *a motion was made and carried that the following slate be elected:*

District Chairmen:

1st: James R. Howerton, M.D., Newport News
2nd: William S. Hotchkiss, M.D., Norfolk
3rd: Henry S. Spencer, M.D., Richmond

4th: Arthur A. Kirk, M.D., Portsmouth
5th: Girard V. Thompson, Sr., M.D., Chatham
6th: Charles A. Young, Jr., M.D., Roanoke
7th: Harvey D. Smallwood, M.D., Charlottesville
8th: Alvin E. Conner, M.D., Manassas
9th: George R. Smith, Jr., M.D., Shawsville
10th: Michael A. Puzak, M.D., Arlington

Members-at-Large:

1st: Keith H. Wolford, M.D., Hampton
2nd: Clarke Russ, M.D., Virginia Beach
3rd: Harold I. Nemuth, M.D., Richmond
4th: Charles H. Moseley, Jr., M.D., Petersburg
5th: A. Epes Harris, Jr., M.D., Blackstone
6th: Mrs. Robert D. Keeling, Woman's Auxiliary, South Hill
6th: James P. Harnsberger, M.D., Hot Springs
8th: Thomas L. Lucas, M.D., Alexandria
9th: William B. Waddell, M.D., Galax
10th: Ira D. Godwin, M.D., Fairfax
10th: Mrs. Marianne Quinnell, Woman's Auxiliary, McLean
10th: W. Leonard Weyl, M.D., Arlington

PSRO

In keeping with the by-laws of the Virginia Professional Standards Review Foundation, the Virginia Hospital Association has nominated a physician for membership on the Foundation's Board of Directors. He is Dr. Robert Berry, Roanoke—considered quite knowledgeable and very well qualified by his colleagues.

A motion by Dr. Alexander to elect Dr. Berry to the Board was seconded and carried.

Council learned that it would also be necessary to elect a member to complete the term of Dr. William M. O'Brien on the Board. Dr. O'Brien recently resigned. Dr. Munoz nominated Dr. John A. Martin to complete Dr. O'Brien's term and *a motion to elect Dr. Martin was seconded and carried.*

HSAs

Dr. Martin reported on the Eastern Regional Health Manpower Conference which he had attended as Dr. Hill's representative. The Conference was held in Roanoke and attracted an attendance of some 200. He pointed out that, of this number, only a very few were physicians.

The Conference concerned itself with the Health Resources and Development Act—generally considered to be one of the most important pieces of legislation passed by the Congress in this century. This new law concerns itself mainly with planning and regulation and will undoubtedly have an unprecedented impact on the practice of medicine in this country.

It was generally agreed that the Society should find some effective way of keeping a close check on developments as they pertain to this law. Regional Health Service Agencies will soon take shape and hope was expressed that representatives of local medical societies could be represented on the appropriate Boards.

Dr. Taylor reported that he had just returned from a Region III HSA Conference in Philadelphia and had learned some very interesting things. It was clear that the law is being interpreted by health planners and this, in itself, could pose a threat to medicine. There is still a great deal to be worked out and the composition of the Boards is still being studied. It was pointed out that providers are very loosely defined as "direct" and "indirect"—meaning that nonphysicians could serve on the various Boards as providers.

Fear was expressed that the law could well be misused for the purpose of dividing and conquering—an age old strategy. The biggest weapon in the HEW arsenal where the law is concerned is its authority to withhold funds when, in its judgment, any of its regulations are not being complied with.

Council was advised that this particular law undoubtedly represents the foundation upon which National Health Insurance will eventually be built and developed. It was learned that conditional HSAs must be ready by January 1. The one catch is that all states apparently must be ready at the same time.

There followed considerable discussion as to how the Society can best serve the interest of medicine where this legislation is concerned. There was some thought that perhaps it might have to enlarge the scope of its legislative activities—even to the point of employing at least one additional person. The thought was also expressed that key individuals from each District should be requested to attend all meetings involving HSA activities in their areas.

A motion by Dr. Kuykendall which would have one officer from each of the five HSA areas attend and monitor HSA activities was seconded but lost.

It was then moved by Dr. Weyl that Council instruct its members to become knowledgeable about HSA objectives and activities and become active in planning and all other activities—including the formation of governing councils. *The motion was seconded and adopted.*

It was then pointed out that all form of involvement by members of the Society must be

coordinated if the results we seek are to be realized.

Last Meetings

Mrs. Hoge, as President of the Auxiliary, and Dr. Martin, as Immediate Past President, called attention to the fact that this would be their last meeting with Council. Mrs. Hoge expressed the hope that future Auxiliary Presidents would be invited to attend Council meetings in order to continue the excellent liaison which now exists between the two groups.

Dr. Martin expressed his appreciation of the opportunity he had been given to serve the Society and stated that it was an experience he would always remember.

There being no further business, the meeting was adjourned.

ROBERT I. HOWARD, *Secretary*

APPROVED:

WILLIAM R. HILL, M.D., *President*

Minutes of the House of Delegates The Annual Meeting, Roanoke

First Session

The House of Delegates of The Medical Society of Virginia met in the Ballroom of the Hotel Roanoke on Thursday, October 23, 1975. The meeting was called to order at 2 p.m. by Dr. William J. Hagood, Jr., Speaker.

The invocation was delivered by Dr. George M. Nipe, member of Council from Harrisonburg.

Dr. G. R. Smith, Jr., Chairman of the Credentials Committee, reported that a quorum was present.

The Rules Committee then presented its report concerning rules and procedures to be followed by the House during the conduct of its business. Dr. William C. Gill, Jr., a member of the Committee, moved that the rules previously distributed to all members of the House be adopted, with the addition of a requirement that all nonmembers of the House be limited to not more than five minutes speaking time. *The motion was seconded and adopted.*

Minutes of the November, 1974, sessions and the August, 1975, special session were approved. The minutes of the 1974 sessions were published in the January, 1975, issue of the *Virginia Medical Monthly*, and those of the special session were to appear in the November issue.

Dr. Hagood addressed the House and called its attention to the many problems facing medicine today. He reminded them of Dr. Murrell's admonition to become involved and stated that this is more important today than ever before. The Speaker indicated that he is doing everything possible to involve as many members as possible in the affairs of the House and pointed out that a Sergeant-at-Arms and an Assistant had been added to the list of this year's appointees. He went on to recall that he had sent a letter last year to all those members who had served on Committees of the House. This year he plans to write all members of the House in an effort to determine what they like—and don't like—about the overall format.

The House then heard Mrs. Randolph H. Hoge, President of the Woman's Auxiliary to The Medical Society of Virginia, report the many accomplishments of the Auxiliary during the year. Of particular interest were those activities having to do with AMA-ERF, local hospital charities, community and international health, legislation, health education, mobile meals, etc. Her report was most impressive and well received.

Also introduced was Mrs. Harold L. Williams, President-Elect of the Auxiliary.

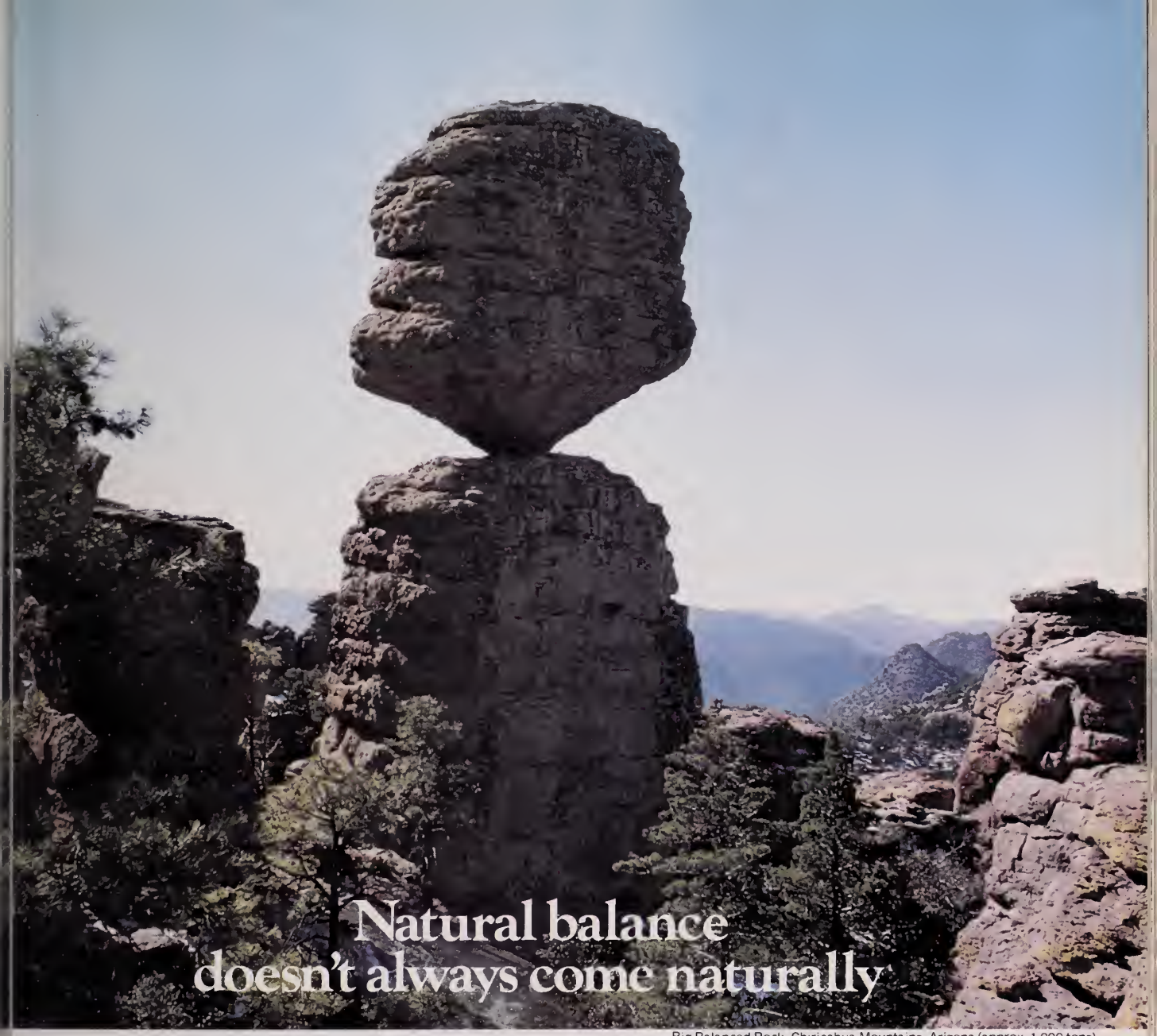
Dr. Hill was introduced and delivered his Presidential Address. He recognized the important and prominent role played by physicians in the American Revolution and called attention to the fact that a number of Virginia physicians served in the Continental Army as combat officers. Other subjects discussed by Dr. Hill were the malpractice problem, continuing education, rural health, American Medical Association, Commissioner of Health, Virginia Council on Health and Medical Care, State Board of Medicine, and the National Health Planning and Development Act.

The President expressed regret over the impending retirement of Miss E. Spencer Watkins as Managing Editor of the *Virginia Medical Monthly*, and that of Dr. Harry J. Warthen as Editor. He pointed out that, between the two, they had contributed over 65 years of service to the physicians of Virginia. A Certificate of Distinguished Service was presented to Dr. Warthen.

Dr. Hill then requested Mr. Beverly Orndorff, Science Writer for the Richmond Times-Dispatch, to come forward and receive a Distinguished Service Award in recognition of his many contributions to medical journalism.

The Presidential Address in its entirety was published in the December, 1975, issue of the *Virginia Medical Monthly*.

The official report of the Credentials Committee was received, and it was learned that a total of 182 delegates were present, representing 43 component societies. The Speaker at this point



Big Balanced Rock, Chiricahua Mountains, Arizona (approx 1,000 tons)

Found useful in the management of vertigo* associated with seases affecting the vestibular system.

Can relieve nausea and vomiting often associated with vertigo.*

Usual adult dosage for Antivert/25 for vertigo:* one tablet t.i.d.

Also available as Antivert (meclizine HCl) 12.5 mg. scored blets, for dosage convenience and flexibility.

Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

.IEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017

Antivert®/25
(meclizine HCl) 25 mg. Tablets
for vertigo*



Documented bioavailability...
Regimen flexibility

q.i.d. or q 6h immediately after or between meals

E-Mycin®

erythromycin enteric-coated tablets, Upjohn

250 mg

Formulated for quality...
Priced for economy.

Upjohn

See facing page for brief summary of prescribing information.

J-4889-9

MYCIN® TABLETS — 250 mg — For Oral Administration (erythromycin enteric-coated tablets, Upjohn)

Mycin Tablets (erythromycin enteric-coated tablets) are specially coated to protect the contents from the inactivating effects of gastric acidity and to permit efficient absorption when administered either immediately after meals or when given between meals on an empty stomach.

Indications: *Streptococcus pyogenes (group A beta-hemolytic streptococci):* Upper and lower respiratory-tract, skin, and soft-tissue infections of mild to moderate severity. Parenteral benzathine penicillin G is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever. When oral medication is necessary (because the parenteral route is contraindicated) or if there is known allergy to penicillin, the following recommendations made by the American Heart Association apply: 1) Oral penicillin G or V (where no allergy exists)—This is the drug of choice. Give for a minimum of 10 days; 2) Erythromycin—Give for a minimum of 10 days. A few strains of streptococci resistant to erythromycin have been reported.

Alpha-hemolytic streptococci (virdans group): Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery where the organisms likely to lead to bacteremia are gram-negative bacilli or the enterococcus group of streptococci.)

Staphylococcus aureus: Acute infections of skin and soft tissue of mild to moderate severity. Resistance may develop during treatment.

Pneumococcus pneumoniae: Upper respiratory-tract infections (e.g., otitis media, pharyngitis) and lower respiratory-tract infections (e.g., pneumonia) of mild to moderate degree.

Mycoplasma pneumoniae (Eaton agent, PPLO): In the treatment of primary atypical pneumonia, when due to this organism.

Treponema pallidum: Infections due to this organism.

Corynebacterium diphtheriae and *Corynebacterium minutissimum:* As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.

Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extra-enteric amebiasis requires treatment with other agents.

Listeria monocytogenes: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.

Precautions: Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.

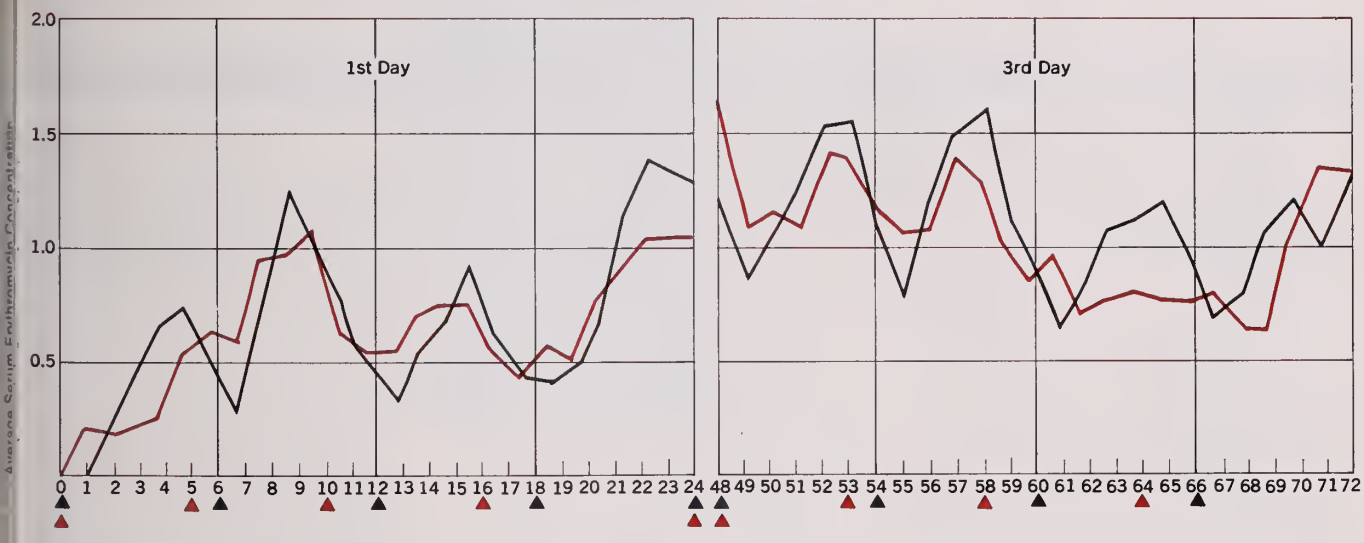
Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of non-susceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

Treatment of overdosage: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdosage should be handled in the usual manner—that is, by the administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug, in addition to all needed supportive measures.

How supplied: 250 mg—in bottles of 100 and in unit-dose packages of 100 enteric-coated tablets. Caution: Federal law prohibits dispensing without prescription.

For additional product information, consult the package insert or see your Upjohn Representative.

emonstrated bioequivalence of E-Mycin taken immediately after meals or between meals.



Regimen A (after meals)—One 250 mg E-Mycin® tablet administered q.i.d. immediately after breakfast, lunch, and dinner, and at bedtime with a snack.

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E-Mycin Study CS076 on file at The Upjohn Company. The study was performed with twenty-two normal male adult volunteers utilizing a randomized two-way complete crossover design.

o statistically significant difference in area under e curve was observed from 0-24 hours or 48-72 ours at the 95% confidence level ($p>.05$).

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ne data clearly demonstrate that E-Mycin, when dministered q.i.d. immediately after meals, proced average serum levels equivalent to those btained when the drug was administered q 6h at ast two hours after meals.

E-Mycin®

erythromycin enteric-coated tablets, Upjohn

250 mg

Formulated for quality... priced for economy

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MED 8-7-S

Opinion & Dialogue

Should a specially prepared package insert be made available to patients?



Dr. Alexander M. Schmidt
Commissioner,
Food and Drug
Administration



Dr. James H. Sammons
Executive Vice President
of the American
Medical Association

The idea of a so-called patien package insert has been around f a long time. Many physicians alre use written instruction sheets to provide patients with information about the drugs they are taking. A some physicians give verbal instru tions; but in too many instances these are what I call eye-glazing e ercises. I have seen patients sit wi glazed eyes listening to a rapid-fir lecture by a hurried physician wh has 20 people out in his waiting room. These patients aren't given sufficient understanding and ther fore do not follow instructions. So think the idea of an official packag insert for patients is a good one. Perhaps we should really think of this kind of information simply as extension of drug labeling.

The benefits of patient involvement

Many physicians may not rea ize how frequently a patient obtair his drug information from Aunt Tillie or the next door neighbor. Ar this information is almost always bad or irrelevant to the case at har Furthermore, the incentive to go along with a prescribed program is slim if the only reading matter the patient receives, along with his pre scription, is a bill.

As an educator I am impresse by the principle that the best way t get someone to do something is to involve him in the process. So the

I think there are advantages a well as some real disadvantages in a patient package insert. When you begin to use semi-medical or medi cal terms to describe complication or possible sequelae of disease or treatment, you may frighten the pa tient—particularly since the more highly sophisticated patient is not the one who is going to read the in- sert. The patient who will read it is the one most susceptible to fright and confusion by the language.

On the positive side, a packag insert will probably give the patient better insight into why he is being treated the way he is, and it may give the physician a little bit more time. But it does not remove from the physician the need or obligation to explain the insert.

Some pitfalls in the inclusion of side effects

Certainly a patient should be warned of the possibility of serious side reactions—to know what the real dangers are. But it doesn't do a bit of good to indicate that a patien on oral penicillin may develop a rash, itching, or a drop in blood pressure. Or that he may faint. I think the real danger is that fright engendered by the insert may pos- sibly outweigh the potential good.

main purpose of drug information or the patient is to get his cooperation in following a drug regimen.

Preparation and distribution of patient drug information

We would hope to amass information from physicians, medical societies, the pharmaceutical industry and centers of medical learning. The ultimate responsibility for uniform labeling must, however, rest with the Food and Drug Administration. There is nothing wrong with this agency saying, "this information is generally agreed upon and therefore it should be used," as long as our process for getting the information is sound.

Distribution of the information is a problem. In great measure it would depend on the medication in question. For example, in the case of an injectable long-acting progesterone, we would think it mandatory to issue two separate leaflets—a short one for the patient to read before getting the first shot and a long one to take home in order to make a decision about continuing therapy. In this case, the information might be put directly on the package and not removable at all. But for a medication like an antihistamine this information might be issued separately, thus giving the physician the option of distribution. This could preserve the placebo use, etc.

It is in the distribution of patient information that the pharmacist may get involved. As professionals and members of the health-care team and as a most important source of drug information to patients, pharmacists should be responsible for keeping medical and drug records on patients. It is also logical that they should distribute drug information to them.

Realistic problems must be considered

We have to expect that the introduction of an information device will also create new problems. First, how can we communicate complex and sophisticated information to people of widely divergent socioeconomic and ethnic groups? Second, what will we say? And third, how can we counteract the negative attitude of many physicians toward any outside influence or input? Hopefully the medical profession will respond by anticipating the problems and helping to solve them. Assuming we can also solve the difficulty of communicating information to diverse groups throughout the United States, our remaining task will be the inclusion of appropriate material.

What information is appropriate?

In my opinion, technical, chemical and such types of material should not be included. And there is no point in the routine listing of side effects like nausea and vomiting which seem to apply to practically all drugs, unless it is common with the drug. However, serious side effects should be listed, as should information about a medication that is potentially risky for other reasons.

Other pertinent information might consist of drug interactions the need for laboratory follow-up, and special storage requirements. What we want to include is information that will help increase patient compliance with the therapy.

Positive aspects of patient drug information

Labeling medication for the patient would accomplish a number of good things: the patient could be on the lookout for possible serious side effects; his compliance would increase through greater understanding; the physician would be a better source of information since he would be freer to use his time more effectively; other members of the health-care team would benefit through patient understanding and cooperation; and, finally, the physician-patient relationship would probably be enhanced by the greater understanding on the part of the patient of what the physician is doing for him.

Only the doctor can remove that fear by 20 or 30 minutes of conversation.

I'm not suggesting that we withhold any information from the patient because, first of all, it would be totally dishonest and secondly, it would defeat the very purpose of the insert. I do think that a patient on the birth control pill should know about the incidence of phlebothrombosis.

If you're going to tell a patient the incidence of serious adverse reactions, then you have to tell him that a concerned medical decision was made to use a particular medication in his situation after careful consideration of the incidence of complications or side effects.

Emotionally unstable patients pose a special problem

There are patients who, because of severe emotional problems, could not handle the information contained in a patient package insert. Yet if we are going to have a package insert at all, we just can't have two inserts. I think we might simply have to tell the families of these patients to remove the insert from the package.

Legal implications of the patient package insert

Just what effect would a patient package insert have on malpractice? We could try to avoid any legal implications by pointing out that the physician has selected a particular medication because, in his professional judgment, it is the treatment of choice. For instance, you can't tell everyone taking antihistamines not to work just because a few patients develop extreme drowsiness which can lead to accidents. And what about the very small incidence of aplastic anemia rarely associated with chloramphenicol? If, based on sensitivity studies and other criteria, we decide to employ this particular antibiotic, we do so in full knowledge of this serious potential side effect. It's not a simple problem.

How do we handle an insert for medication used for a placebo effect?

With rare exceptions, physicians no longer use medications for a placebo effect. This question does raise the issue of how a patient may react to receiving a medication without a package insert.

Preparation of the package insert

The development of the insert ought to be a joint operation between physicians, the pharmaceutical industry, the A.M.A. and the F.D.A.

I view the A.M.A.'s role as a coordinator or catalyst. It is the only organization through which the profession as a whole, irrespective of specialty, can speak. It has relatively instant access to all the medical expertise in this country. And it can bring that professional expertise together to ensure a better package insert. The A.M.A. can work in conjunction with the industry that has produced the product and which is ultimately going to supply the insert.

I don't think we should rely, or expect to rely, on legislative committees and their nonprofessional staffs to make these decisions when it is perfectly within the power of the two groups to resolve the issues in the very best American tradition—without the government forcing us to do it. I think the F.D.A. has to be involved, but I'd like them to become involved because they were asked to become involved.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005



advised the various component societies of their options concerning the appointment of delegates to complete their quotas.

The Speaker next recognized Dr. Richard E. Palmer, President-Elect of the American Medical Association. Dr. Palmer reported that AMA has made a strong comeback from the very brink of financial catastrophe. As a result of a number of decisive actions, the Association has adjusted its financial needs to the point that it is operating on a very sound basis. Dr. Palmer stated that AMA is today "a great deal leaner but also a great deal stronger". He also revealed that negotiations are now under way for the possible sale of *Today's Health*. The House was pleased to learn that AMA membership is at an all-time high, and growing. It is likely that some of the growth can be attributed to the aggressive action of AMA in taking HEW into the Federal Courts.

Following Dr. Palmer's address, the Speaker introduced Dr. Hoyt D. Gardner, member of the AMA Board of Trustees, who was representing the Kentucky Medical Association; Dr. William H. Cooper, President, Medical Society of District of Columbia; Dr. John R. Davis, representing the Medical & Chirurgical Faculty of the State of Maryland; and Dr. Jack Leckie, President, West Virginia State Medical Association.

Mr. Edward DeBolt, Director of the Society's educational campaign for malpractice legislation, discussed his activities and some of the main points covered in a special informational brochure just released. He indicated that a final victory can be won only if individuals other than physicians speak out. Mr. DeBolt deplored the complacency on the part of many and stated that this is the one thing, above all others, which could cause failure. It is to be avoided at all costs.

Next to be introduced was Dr. Rex E. Kenyon, member of AMPAC Board of Directors, Oklahoma City. Dr. Kenyon called for total support of VaMPAC and AMPAC by physicians and pointed out that dollars made available through political action committees have the most political clout. It was brought out that without such committees the necessary dollars would never be forthcoming. Only in this organized fashion can the results we seek be realized.

The Speaker then introduced Mrs. Myrtle Ingvaldsen, President, American Association of Medical Assistants, Virginia Society; Dr. Virgil H. Marshall, President, Virginia State Dental Association; and Mr. Harvey B. Morgan, President, Virginia Pharmaceutical Association. Mr. Morgan told the House that pharmacy has become more patient-oriented than product-oriented and has a great deal to offer the medical profession. He stated that pharmacy has no intention of infringing on the practice of medicine and expressed the hope that better communications could be developed between the two professions.

The Speaker reported that Miss Margaret Hanley, President of the Virginia Nurses' Association, had been in attendance but had to leave just prior to introductions.

Dr. Hagood then announced those special committees directly concerned with the operation and functioning of the House of Delegates. The Speaker announced the names of the Chairmen of the various District delegations and proceeded to cover their duties in detail. He explained that there would be a short recess during which time special guests might be excused, should they so wish, and during which time nominees to the Committee on Nominations should be selected. Later caucus meetings should be scheduled at that time for the purpose of determining who they would nominate and support for the various offices. The odd numbered Districts were reminded that they should decide on those to be nominated for the office of Councilor. All Districts would be concerned with the nomination of Vice-Councilors. The attention of the Third and Fourth Districts was called to the fact that they must submit three nominations each for appointment to the Virginia State Board of Medicine.

Following a 10-minute recess, the Speaker was assured by the Chairman of the Credentials Committee that a quorum was present. Members of the Nominating Committee were then announced and elected.

Dr. Michael Puzak, Chairman of the Finance Committee, presented the annual financial report and a proposed budget for 1975-76. The House was advised that the Society had enjoyed another excellent year financially and that this could be attributed in large part to the returns derived from sound investments. Dr. Puzak reported two changes in the budget as recommended by Council earlier in the day. The proposed budget was then referred to a Reference Committee for consideration the following afternoon.

Committee reports were then accepted and referred to Reference Committees. The Speaker reminded the House that Committees have been requested to submit their reports to the State office at least 60 days prior to the annual meeting. Only in this way can they be printed in the *Virginia Medical Monthly* in time for members of the House to study them in detail.

At this point Dr. William Hotchkiss was introduced for the purpose of presenting a supplemental report from Virginia's AMA Delegates. Dr. Hotchkiss reviewed the AMA financial crisis, its efforts to assist with the malpractice prob-

lem, its thus far successful venture into the Courts, and the election of Dr. Palmer as President-Elect.

A call for new business was issued, and the Speaker stated that all resolutions previously distributed would be referred to Reference Committees. New resolutions would be introduced from the floor—only the "Resolved" portion being read. These also would be referred to Reference Committees.

The following resolutions were then introduced:

Optometry and Drugs—sponsored by Norfolk County Medical Society.
Consolidation of Licensing and Inspections—sponsored by Norfolk County Medical Society.
Protection of Elderly—sponsored by Norfolk County Medical Society.
Alternate Sources of Professional Liability Insurance Coverage—sponsored by Component Societies of the Second District.
Continuing Medical Education and Membership—sponsored by Alexandria Medical Society.
Merger of Blue Shield Plans—introduced by Dr. Gene Clapsaddle.
Extension of Pharmacy in Practice of Medicine—sponsored by Alexandria Medical Society.
Collective Bargaining—sponsored by Component Societies of the Eighth District.
Unified Membership—sponsored by Alexandria Medical Society.
Unified Membership—introduced by Dr. Anthony J. Munoz.

The Speaker requested the Committee on Nominations to meet with him immediately following adjournment in order to determine a time and place for its meeting. He also reviewed basic guidelines for the conduct of Committee business.

Dr. Hagood then announced that all Reference Committees would meet the following afternoon at 2 p.m. and that detailed information, including agendas, would be posted in the registration area early Friday morning.

After announcing the time and location of the next meeting of the House on Saturday, Dr. Hagood alerted the House to a possible General Session of the Society should proposed amendments to the By-Laws be adopted. The meeting was then recessed.

Robert I. Howard, *Secretary*

APPROVED:
William J. Hagood, Jr., M.D., *Speaker*

PRO and CON

Final action by the House of Delegates at the annual meeting resulted in these positions to be taken by the Society on legislative items slated for the 1976 session of the Virginia General Assembly.

Support

The Medical Society of Virginia's Malpractice Bill
Protection of the Elderly Study
Consolidation of Licensing and Inspection Study
Medical Staff Review Committees Bill
Audiology Bill

Oppose

Bills relating to Optometry and Drugs
Mandatory Continuing Medical Education Bill
Death with Dignity Bill
Prescription Drug Substitution or Formulary Bill

Second Session

The second session of the House of Delegates was called to order by the Speaker at 2 p.m. on Saturday, October 25, 1975, at the Hotel Roanoke. A quorum was announced by Dr. G. R. Smith, Jr., Chairman of the Credentials Committee.

After inquiring if there were any members who wished to qualify as Delegates for their component societies, the Speaker called for reports of the Reference Committees.

Dr. E. O. S. Stevenson was then called upon to present the report of Reference Committee No. 1.

Reference Committee No. 1

Report of Council:

The following items contained in the report of Council were approved: Health Manpower Legislation, Professional Gross Receipts Tax, National Health Insurance, Hold Harmless Contracts, Legislative Seminar, Reporting Endorsement, and Professional Liability Risk Categories.

Two items contained in the report, Legislative Campaign and Special Assessment, required no action on the part of the House and, consequently, were filed.

Acting upon the Committee's recommendation, the House referred back to the Legislative

Committee for further consideration that item having to do with Right of Discovery.

Health Service Agencies:

It was recommended by the Committee that the House permit, through unanimous consent, introduction of a resolution having to do with PL 93-641. Dr. Hagood explained those options available to the House and called attention to Item 8 of the Rules of Procedure.

A motion to permit introduction of the resolution was unanimously adopted.

A followup motion by Dr. Moss that the resolution be considered through the medium of informal consideration was seconded and carried.

Dr. Wyndham B. Blanton, Jr. discussed the reasons for the resolution and indicated that the recent action of Council was not, in his judgment, sufficient. He indicated that a resolution is needed which requires a positive action to assure medicine its proper representation on HSA governing councils.

Dr. David Brillhart moved that an additional "Resolved" be added which would review the Federal decision placing the Counties of Washington and Scott in a Tennessee Health Service Area. *His motion was adopted.*

Dr. Weyl then moved to amend the second "Resolved" by eliminating the word "subcommittees" and substituting the phrase "*a committee from component medical societies*". *The amendment was adopted.*

Following approval of a motion to extend debate, *the resolution, as amended, was adopted* and follows in its entirety:

WHEREAS, PL 93-641 became law in the United States on January 5, 1975, and

WHEREAS, the Health Service Areas provided for by this legislation have already been conditionally established—five in Virginia, and

WHEREAS, the governing bodies of these HSAs must be designated by July 4, 1976, and

WHEREAS, these must include health care providers as one-third of the governing body membership and may not include a majority of providers (providers being defined to include (1) physicians, dentists, nurses, and other professionals; (2) health insurers; (3) health care professional schools; (4) health care institutions), and

WHEREAS, the HSA is directed and empowered to (a) annually establish an area health system plan, (b) annually implement such a health system plan, (c) enter into a written agreement with the PSRO of the area to ensure coordinated approaches, and (d) review and recommend as to the "appropriateness" of all health care institutions in the area (at least every five years), and

WHEREAS, the importance of these HSAs is compounded by the fact that the State Health Coordinating Council which will exert great state-wide influence (including Federal finance) under PL 93-641 is required to be made up primarily of membership from all local HSAs, and

WHEREAS, this law in total provides for maximal control of health care under government sponsorship with minimal input from physicians at best, therefore be it

RESOLVED, that The Medical Society of Virginia declare it to be imperative that the maximum possible number of physicians be a part of the governing bodies of the HSAs and the State Helath Coordinating Council and that such be physicians who can forcefully and truly represent medicine, and be it further

RESOLVED, that The Medical Society of Virginia, in its concern, appoint a State Committee with a committee from component medical societies in each designated HSA to adopt and implement a positive plan of action to maximize these appointments and to meet this crisis, and be it further

RESOLVED, that The Medical Society of Virginia recommend to the Governor and Attorney General that all possible means be explored to reverse the Federal decision to place the Counties of Washington and Scott in the State of Tennessee HSA.

Resolution on Medicare Notification of Payment:
(Introduced by Dr. J. D. Skaggs)

Acting upon the Committee's recommendation, *the following resolution was adopted:*

WHEREAS, the Medicare program has established itself as a permanent program and many of our patients are covered under this program, and

WHEREAS, many Medicare patients are unable to manage their financial matters and do not understand the payment method, and

WHEREAS, the physicians of our State desire to help Medicare patients but should not have to feel compelled to accept assignment in order to accomplish this end, and

WHEREAS, it would help both patient and physician if a copy of the "explanation of benefits" were sent to the physician when payment is made to the patient; be it

RESOLVED, that The Medical Society of Virginia request the carrier of Part B Medicare in Virginia (Travelers Insurance Company) to send a copy of the "explanation of benefits" to the provider of the services (the physician) when payment is made directly to the patient.

Presidential Address:

The Committee commended Dr. Hill on his excellent Presidential Address, particularly that portion having to do with the history of the Society's malpractice bill. *The House concurred.*

Also approved was the recommendation in Paragraph 26 urging that the Sick Physician Act be included in hospital by-laws. *The House also concurred* with the Committee's recommendation that Dr. Hill's comments in Paragraph 27, relating to support for VaMPAC, be accepted.

Committee Reports:

The following reports were approved as recommended: Insurance, By-Laws, Legislative, and Professional Liability. The Speaker called attention to a proposed amendment to Article XVI of the By-Laws contained in the report of the By-Laws Committee. *The House voted by over ⅔ majority to adopt the amendment.*

Article XVI now reads as follows:

These By-Laws may be amended at an Annual session by two-thirds vote of the House of Delegates, and ratified by a general meeting of the Society. By-Laws amendment may be proposed by any member. Such proposal shall be submitted in writing through the Executive Vice-President. The By-Laws Committee shall consider and make a recommendation for disposition of all properly proposed amendments in its report to the House of Delegates. Amendments made at the time of the Annual Meeting shall lay on the table at least twenty-four hours before they may be considered for adoption and shall be handled in accordance with rules established by the House of Delegates in accordance with Article VII, Section 2. All previous Constitutions and By-Laws of the Society are repealed when these By-Laws are adopted and put into effect.

Resolution on Protection of the Elderly:
(Sponsored by Norfolk County Medical Society)

Acting upon the Committee's recommendation, *the House adopted the following resolution:*

WHEREAS, the State recently passed a law which gave protection to the elderly, which was similar to that afforded by the Child Abuse Laws; and

WHEREAS, efficiency of this law was reduced by requiring that the individual being protected agree to allow the protection to occur; and

WHEREAS, Departments of Welfare and Health have been repeatedly faced with the problems of the senile elderly who is in need of protection, yet will not permit intervention in his behalf; now therefore, be it

RESOLVED, that the State Legislature consider a review and revision of the laws granting protection to the elderly so that in the event the individual will not, or cannot, agree to being assisted, society will have a way of initiating assistance that does not imply mental derangement or require prolonged court action.

Resolution on Consolidation of Licensing and Inspection:
(Sponsored by Norfolk County Medical Society)

It was the Committee's recommendation that the first "Whereas" be amended by adding the words "*day care centers*" following the words "half way houses,". *The House concurred* and the following resolution was adopted:

WHEREAS, many problems arise from multiple agency responsibility for licensing and inspection of old age homes, homes for the mentally retarded, homes for the mentally disturbed, mental after-care facilities, intermediate care facilities, half-way houses, day care centers, etc., and

WHEREAS, at the present time Departments of Health, Mental Health, Social Service, the State Fire Marshall's office, and perhaps others are involved in the periodic review and licensing of institutions for the care of special categories of persons, and

WHEREAS, licensing and inspections have been tied together in what is probably a reasonable relationship because of the need to have prior inspection before state licenses are issued, and

WHEREAS, the State has created a whole series of special agencies based on certain categorical characteristics of the institution being licensed and inspected, and

WHEREAS, there are at least three separate departments having three separate inspectional agencies who are managed by three separate management establishments. Each of these sets

individual standards and each reviews its special institutions in a different manner, and

WHEREAS, the primary purpose is to protect the health and safety of the client utilizing the institution, and

WHEREAS, each categorical agency is funded in a limited fashion and has been assigned limited manpower, the number of inspections available throughout the State are extremely limited; therefore, be it

RESOLVED, that consolidation of all licensing and inspection agencies for categorical institutions under one department and assigning the responsibilities to that department would result in a greater level of consistency in the demands made on the institutions and a greater level of efficiency in the inspection process and that since the State Health Department, in cooperation with the localities, has a widespread network of environmental, nursing and physician personnel throughout the State, that greater consistency and efficiency would result by assigning responsibility for inspection and licensing to the State Department of Health than by creating a new departmental agency for this consolidation.

Resolution on Optometry and Drugs:
(Sponsored by Norfolk County Medical Society)

The House agreed that the following resolution should be adopted:

WHEREAS, the diagnosing of diseases and the administration of drugs constitutes the most essential part of the practice of medicine, and

WHEREAS, one with less than the medical education and training of a physician is not competent to make a proper judgment concerning the presence or absence of disease and the effects of drugs related thereto, and

WHEREAS, a course in pharmacology is no substitute for medical education, therefore be it

RESOLVED, that The Medical Society of Virginia is opposed to the administering or prescribing of diagnostic or other drugs by optometrists.

Resolution on Alternate Sources of Professional Liability Coverage:
(Sponsored by Component Societies of the Second District)

The Committee reported that this particular resolution had stimulated a tremendous amount of discussion and that numerous comments and suggestions had been received from a number of members and special guests. After carefully weighing all the testimony presented, it was the Committee's recommendation that the words "and secure" be deleted from the "Resolved" portion.

Dr. Robert Morton offered a substitute motion to amend the original resolution by deleting the entire "Resolved" portion and substituting completely new language in its place. The new "Resolved" would have the Society approve in principle a program of professional liability coverage by a physician-owned and controlled company and consider such a program as an acceptable alternate source of such coverage for Virginia physicians. It went on to say that such a program would provide a means by which Virginia physicians, through their participation in policy making, could determine their own destiny with respect to such coverage. It also directed Council to proceed expeditiously along the lines mentioned.

There followed considerable discussion during which the thought was expressed that time is running out and that the Society can no longer afford the time necessary for further investigation.

Dr. Morton's substitute motion was then adopted.

Later in the proceedings, the House adopted a motion by Dr. Fields to reconsider the above action on Alternate Sources of Professional Liability Coverage.

A motion was then made by Dr. Weyl to modify and amend Dr. Morton's substitute motion by deleting all language which he considered unnecessary and superfluous. *His motion carried* and the resolution follows in its final form:

WHEREAS, The Medical Society of Virginia has, since 1954, been evaluating and providing for its members, a program for professional liability insurance, and

WHEREAS, the premiums for professional liability coverage have increased significantly, and further increases may be expected to occur if affirmative action is not taken to moderate the cost of such insurance, and

WHEREAS, the continued availability of professional liability insurance must be assured to the members of this Society, in order to continue the delivery of quality medical care to the citizens of the Commonwealth of Virginia, and

WHEREAS, this Society believes that there should be acceptable alternatives to the physi-

cians of this State in placing their professional liability coverage, and

WHEREAS, the physicians in several surrounding states have been placed in the position of becoming uninsured when a major insurer withdrew its coverage, therefore be it

RESOLVED, that The Medical Society of Virginia does hereby approve in principle the development of a program of professional liability insurance coverage offered by a Virginia physician owned and controlled company as an alternative insurance program.

Resolution on Merger of Blue Shield Plans:
(Introduced by Dr. Gene Clapsaddle)

The House agreed with the Committee's recommendation that this resolution be referred to an ad hoc committee for further study and that a report of its findings and recommendations be submitted to Council as soon as practical.

Resolution on Collective Bargaining:
(Sponsored by Component Societies in Eighth District)

The House was advised that the Committee had given a great deal of thought to this particular resolution and recommended that it be referred to Council for further consideration.

Dr. Glenn Thompson introduced a substitute motion which would amend the resolution by substituting the word "*negotiating*" for the words "collective bargaining". It would also add an additional "Whereas" indicating that AMA has already established a Department of Negotiation.

The substitute motion was carried and the resolution adopted in the following form:

WHEREAS, the practicing physician in the Commonwealth of Virginia has no one to defend his interests in dealing with third party systems and other forces encroaching upon the private practice of medicine; and

WHEREAS, one physician alone is unable to deal effectively with encroachments while meeting his professional obligations; and

WHEREAS, The Medical Society of Virginia is the already acknowledged voice of medicine in Virginia; and

WHEREAS, the American Medical Association has already established a Department of Negotiation; now, therefore, be it

RESOLVED, that The Medical Society of Virginia be recognized as the negotiating agent of all Virginia physicians; and be it further

RESOLVED, that an ad hoc committee of the Society be appointed to develop a branch of the Society to represent Virginia physicians in negotiating in every facet of practice where unified representation is needed; and be it further

RESOLVED, that every physician-member of The Medical Society of Virginia shall be bound by the agreements forged by his representative, The Medical Society of Virginia.

Resolution on Medical Staff Review Committees:
(Sponsored by Fairfax County Medical Society)

It was the recommendation of the Committee that the last line in the "Resolved" portion following the words "Medical Staff Review Committees" be amended by adding "*hospital staff review committees, PSROs, and any other similar organizations,*". *The House concurred and the following resolution was adopted as amended:*

WHEREAS:

1. Medical Staff Committee meetings are held to review and improve medical standards and quality of patient care.
2. Confidentiality of these meetings is essential to effective functioning.
3. Subjecting these deliberations and discussions to the discovery process would terminate such deliberations.
4. A local hospital was requested to disclose the last 50 cases handled by certain physicians which came before the Medical Audit Committee and the evaluation of that Committee.
5. The Fairfax County Circuit Court sustained objections by legal counsel for the Hospital to such discovery based on the public consideration.
6. The Virginia Supreme Court or the United States Supreme Court has never ruled on this point, another Virginia Circuit Court judge would be free to make a contrary decision.

RESOLVED: That The Medical Society of Virginia encourage the Virginia State Legislature to enact a Virginia statute, similar to those already enacted in California and Nebraska, which would prohibit the proceedings and records of Medical Staff Review Committees, hospital staff review committees, PSROs, and any other similar organizations, from being subject to discovery.

Supplemental Report of Legislative Committee:

The following items contained in the supplemental report were adopted as recommended: (1)

Annuity Payment or Trust Amendment, (2) Pronouncement of Death, (5) MIST Program, (7) Prescription Drug Substitution and Formulary Bill, (8) Fifth Pathway Legislation, (9) Impaired Motor Vehicle Drivers, (11) Audiologists Bill, (12) Possible Legislation Killed During Last Session, (14) Refusal of Home Treatment, and (16) Commitment for Mental Observation.

Item (3) having to do with Right of Discovery was re-referred to the Legislative Committee for further consideration.

The House agreed that a final determination of position on Mandatory Continuing Medical Education should be referred to Council if such legislation is introduced during the 1976 Session of the General Assembly.

Death With Dignity was discussed at great length and *the House agreed* with the Committee that the so-called Death With Dignity Bill be rejected and that the Society record its opposition.

Also adopted was the Reference Committee's recommendation that the Society oppose mandatory "full maternity" coverage in medical and health insurance contracts sold in Virginia.

The House went on to reject the recommendation of the Legislative Committee pertaining to Nurse Midwives and *approved* instead *the recommendation of the Joint Practice Committee.*

Acting on the Reference Committee's recommendation, the House rejected the recommendation of the Legislative Committee relative to Central Licensing Agencies. The rejection was based on the fact that a resolution for consolidation and inspection had been approved earlier.

Following rejection of a motion to reconsider the Death With Dignity question, *the report of Reference Committee No. 1 as a whole, as amended, was adopted.*

Dr. Thomas L. Gorsuch was next called upon to present the report of Reference Committee No. 2.

Reference Committee No. 2

Committee Reports:

The following reports were approved as recommended: Executive Vice-President, Public Relations, Membership, Virginia Joint Practice Committee, Advisory to Woman's Auxiliary, Venereal Disease, Long Range Planning Committee, and Rehabilitation.

Approved was the Reference Committee's recommendation that the report of the Maternal Health Committee be approved with two exceptions. The exceptions referred back to Council the matter of forming a "Family Life Education Committee" and also the matter of forming a committee for the purpose of implementing the regionalization concept for maternity care in Virginia.

The House concurred that the report of the Committee on Child Health be referred back to the Committee for clarification of its recommendations and conclusions on Pre-School Health Examinations, Immunizations, Newborn Insurance, Nurse Practitioners, and Programs for Gifted Children.

The House agreed with the Committee's recommendation that the report of the Committee on Medical Aspects of Sports be approved, with the exception of that paragraph covering proposed solutions to the serious potential of medical liability faced by team physicians who are forced to act in serious emergency situations with sparse or nonexistent ancillary medical aid. This portion of the report was referred back to the Committee on Medical Aspects of Sports in order that it might prepare a new recommendation for future consideration by the House.

Report of Commission on Continuing Medical Education:

The Reference Committee indicated that this particular report had been reviewed with great interest and that its members were quite impressed with the progress made by the Commission during the past year. The Commission was commended on the quality and excellence of its presentation. *The House agreed with the recommendation that the report be approved.*

Report of Council:

The following items contained in the Report of Council to the House were approved: Headquarters Building, 1980 Annual Meeting, Special Representation, MIST Program, Orndorff recognition, and State Board of Medicine.

The House agreed that that portion of the report having to do with Health Fairs and Laboratory Tests was of sufficient importance for it to be referred back to Council, or an appropriate Committee, for further study and more definitive action.

Resolution on Continuing Medical Education and Society Membership:
(Sponsored by Component Societies in the Eighth District)

Acting on the Committee's recommendation, *the following substitute resolution was adopted:*

> Resolved, that The Medical Society of Virginia require that each active member of the Society participate in a program of Continu-

ing Medical Education as determined and certified by the Commission on Continuing Medical Education in order to maintain active membership in The Medical Society of Virginia, and be it further

RESOLVED, that this requirement take effect as of January 1, 1977, and be it further

RESOLVED, that this resolution be referred to the By-Laws Committee for appropriate changes in the By-Laws in order that they may be presented at the 1976 meeting of the House of Delegates.

Later in the proceedings, *the House adopted a motion by Dr. Cook to reconsider this particular resolution. A motion to amend* by adding the words "*and charter*" after the words "By-Laws" in the second line of the last "Resolved" *was adopted.* Such an amendment was considered necessary from a technical point of view.

Annual Meeting:

At this point in the proceedings, Dr. Martin expressed the feeling that it might be well to extend the length of the Annual Meeting by one day. He indicated that the numerous activities posed a difficult scheduling problem and that it was not possible for those attending to participate in all the functions they would like. The thought was expressed that Council might well give Dr. Martin's suggestion serious consideration.

Unified Membership:

Two resolutions on this most important subject were considered by the Committee, one sponsored by the Alexandria Medical Society and the other introduced by Dr. Anthony J. Munoz. The Committee had agreed that both resolutions, along with Item 18 of the Report of Council, should be considered jointly. After weighing the great amount of testimony received on the subject, the Committee recommended, *and the House concurred*, that Item 18 of the Council Report be accepted. It also recommended that the two resolutions be replaced by a substitute resolution.

Dr. Munoz moved to amend the substitute resolution by adding the words "*and charter*" after the words "By-Laws" in the second line of the last "Resolved". His motion was carried.

Following a considerable amount of discussion on the overall question of Unified Membership, debate was terminated and *the following substitute resolution adopted as amended:*

RESOLVED, that membership in the AMA be a requirement for active membership in The Medical Society of Virginia, and be it further

RESOLVED, that the By-Laws Committee of The Medical Society of Virginia be instructed to prepare appropriate amendments to the By-Laws and Charter for implementation of this resolution and that this be presented to the House of Delegates at its Annual Meeting in 1976.

Presidential Address:

In keeping with the Committee's recommendation, that portion of Dr. Hill's Presidential Address found in paragraphs 12 through 20 was *approved in its entirety.*

The report of Reference Committee No. 2 as a whole was then adopted as amended.

The Speaker then called on Dr. John Hortenstine to present the report of Reference Committee No. 3.

REFERENCE COMMITTEE NO. 3

Committee Reports:

In keeping with the Committee's recommendation, *the following reports were approved:* Ethics, Editorial Board, Virginia Medical Bicentennial, Sight Conservation, Health Careers, Liaison to State Bar, Pharmacy, Liaison to Virginia Hospital Association, and Regional Medical Program.

The House also approved the AMA Delegates' Report and the Special Report by Dr. William S. Hotchkiss. Special notice was taken of those portions of the report having to do with the AMA dues increase and the positive action taken in connection with the Utilization Review Issue.

The House concurred with the Reference Committee's recommendation that the report of the Committee on Mental Health be approved. It noted that a great deal of consideration had been given to that section of the report having to do with the 48-hour commitment deadline. As a result, the Committee on Mental Health was requested to continue to seek some solution to this particular problem and make its findings known in next year's annual report.

Resolution on Practice of Medicine by Pharmacists:
(Sponsored by Alexandria Medical Society)

It was recommended by the Committee that the first "Whereas" of this resolution be amended by deleting reference to professional status. *The House concurred* and the resolution, as amended, was adopted as follows:

There's something special about children vomit

The risk of dehydration . . . plus the psychologic
stress on both mother and child . . .
greatly increases the urgency in controlling von
in children. In addition, there is, of course, need
avoid the extrapyramidal problems associated v
phenothiazine medications.



hat's why special medication is preferred

ANS® CHILDREN SUPPRETTES™ are specially formulated to stop vomiting and nausea in children—rapidly and with minimal complications.

- WANS are administered rectally—often the best route in the vomiting patient.
- The exclusive WANS formula provides both pyrilamine maleate and sodium pentobarbital for effectiveness . . . contains no phenothiazines or local anesthetics.
- The unique Supprette delivery system rapidly releases effective levels of medication . . . with no gums or fatty acids to affect absorption or cause local irritation.
- WANS SUPPRETTES require no refrigeration . . . no lubrication other than water . . . and dissolve completely, with virtually no leakage.

d for children over 12 years of age and adults suffering from nausea and vomiting, consider higher-strength WANS® No. 1 or WANS® No. 2.

A special favorite* of Virginia physicians in controlling childhood vomiting



WANS® CHILDREN SUPPRETTES™

rectal antinauseant/antiemetic

pyrilamine maleate 25 mg; sodium pentobarbital 30 mg
Warning: may be habit forming

*Based on usage by dosage form; data gathered by independent research organization.

ESCRIPTION: WANS® Children: (Blue) pyrilamine maleate mg and pentobarbital sodium* ½ gr (30 mg) scored for dosage. WANS® No. 1: (Pink) pyrilamine maleate 50 mg d pentobarbital sodium* ¾ gr (50 mg) scored for ½ dosage. ANS® No. 2: (Yellow) pyrilamine maleate 50 mg and ntobarbital sodium* 1½ gr (100 mg) scored for ½ dosage.

ARNING: may be habit forming.

ONTRAINDICATIONS: Infants under 6 months. Acute ermittent porphyria, known hypersensitivity to barbiturates antihistamines, known previous barbiturate addiction, vere hepatic impairment, CNS injury, senility, and presence uncontrolled pain.

ARNINGS: Barbiturates may be habit forming. Pre-existing ychologic disturbances may be aggravated. Idiosyncratic actions may occur. Acquired sensitivity may result in allergic actions. Safety in pregnancy has not been established.

RECAUTIONS: Use cautiously with other sedative, hypnotic narcotic agents. Use with caution in patients with acute or ronic hepatic disease, fever, hyperthyroidism, diabetes llitus, severe anemia, congestive heart failure, or a history drug dependence or suicidal tendencies. May impair rtness and coordination with increased accident risk.

ADVERSE REACTIONS: Drowsiness, fatigue, vertigo, incoordination, tremor, muscle weakness, ataxia, hypotension, respiratory depression, delirium and coma. Dryness of nose, mouth, and throat, pupillary dilatation or blurred vision, urinary retention, abdominal pain, nausea, vomiting, diarrhea, and hypersensitivity reactions. Overdose may result in hallucinations, excitement, ataxia, incoordination, athetosis, convulsions, and death.

DOSAGE AND ADMINISTRATION: Rectally, children 2-12 years of age, one WANS® CHILDREN every 6-8 hours as required. Children under 2 years of age may receive ½ the above dosage. *Adults:* Rectally, one WANS® No.1 Supprette™ to inhibit mild nausea and/or vomiting; one WANS® No. 2 Supprette to control pernicious vomiting. Repeat doses for adults should be 4 to 6 hours apart, not to exceed four doses in 24 hours. Moisten finger and Supprette with water before inserting. Optimum dosage must be determined in each case by the clinical response.

WEBCON

Webcon Pharmaceutical Division
Alcon Laboratories, Inc.
Fort Worth, Texas 76101

WHEREAS, there has been an extension of services which includes product selection, patient instruction and also certain diagnostic procedures, therefore be it

RESOLVED, that The Medical Society of Virginia oppose the further extension of the practice of pharmacy into the practice of medicine, and be it further

RESOLVED, that the Pharmacy Committee of The Medical Society of Virginia be instructed to meet with a Liaison Committee of the Virginia Pharmaceutical Association at regular intervals so that continuing dialogue between these two organizations is maintained.

Report of Council:

The House agreed that the following items contained in the Report of Council should be approved: . New Component Society, Drug Repackaging, Cosmetic Surgery, Editor Emeritus, Physician Strikes, and Allowable Mileage Rate.

That portion having to do with Community Medical Directories was approved with the recommendation that the Society inform the various Comprehensive Health Planning Councils of its action.

Financial Report and Budget:

The Committee called attention to the fact that the Society had enjoyed another excellent year financially and that a balanced budget for fiscal year 1975-76 had been presented for its consideration. *The House then voted to adopt the following budget for fiscal 1975-76:*

EXPENSES:	*Proposed*
Salaries (includes Dir., Contg. Educa.)	$135,000.00
Telephone & Telegrams	5,000.00
Postage	4,000.00
Stationery & Supplies	5,500.00
Office Equipment–Repairs & Replacements	1,500.00
Building Maintenance & Repairs–net	14,000.00
Convention Expenses	10,000.00
Council and Committee Expense	5,000.00
Travel Expense:	
Executive Assistant	600.00
Delegates to AMA	9,500.00
President	3,000.00
Executive Vice President	2,100.00
Component Society Liaison	500.00
Virginia Medical Monthly	60,000.00
Legal Expense	20,000.00
Walter Reed Commission	500.00
Woman's Auxiliary	250.00
Membership Dues (Affiliated Organizations)	480.00
Editor–Virginia Medical Monthly	1,000.00
VaMPAC (Educational Fund)	14,000.00
Newsletter	2,500.00
Retirement Fund	20,000.00
Payroll Taxes	7,000.00
Public Relations	1,000.00
Legislative Expense	6,500.00
Miscellaneous	1,000.00
SPECIAL APPROPRIATIONS:	
Virginia Council	5,000.00
AMA-ERF	1,000.00
Rural Health	500.00
Scholarship–MCV–(Administered by The Medical Society of Virginia)	2,000.00
Scholarship–UVA School of Medicine–(Administered by The Medical Society of Virginia)	2,000.00
Scholarship–Eastern Virginia Medical School–(Administered by The Medical Society of Virginia)	2,000.00
National Society for Medical Research	150.00
Miscellaneous AMA	600.00
Insurance Study	3,000.00
Consulting Services (Malpractice Legislation)	45,000.00
Audit of Retirement Programs	1,500.00
Building Fund	25,000.00
TOTAL	$417,680.00

Presidential Address:

Those portions of Dr. Hill's Presidential Address contained in paragraphs 1 through 4 and 28 through 33 *were approved* as recommended.

Speaker's Remarks:

The Committee commended Dr. Hagood on his efforts to shape and conduct the business of the House in keeping with the wishes of the majority. *The House approved* the Committee's recommendation that the remarks of the Speaker be accepted.

The report of Reference Committee No. 3 as a whole was adopted.

* * * * *

Dr. Hagood reviewed the procedure to be followed in the elections of officers, delegates, etc.

The report of the Nominating Committee was then presented by Dr. John D. French, Chairman.

Dr. W. Leonard Weyl was nominated for the office of President-Elect and unanimously elected.

Dr. Gervas S. Taylor, Jr. was elected First Vice-President; Dr. W. Robert Irby, Second Vice-President; and Dr. Douglas E. Pierce, Third Vice-President.

Re-elected as Speaker and Vice-Speaker were Dr. William J. Hagood, Jr., and Dr. K. K. Wallace, Jr.

Robert I. Howard was re-elected Executive Vice-President.

Elected to Council from the odd numbered Districts were the following:

1st District:	Dr. Harold L. Williams (re-elected)
3rd District:	Dr. Charles M. Caravati, Jr.
5th District:	Dr. Girard V. Thompson, Sr. (re-elected)
7th District:	Dr. George M. Nipe (re-elected)
9th District:	Dr. James Hal Smith (re-elected)

Dr. C. Barrie Cook was elected to complete the unexpired term of Dr. W. Leonard Weyl.

The following Vice-Councilors were then elected:

1st District:	Dr. William Stewart Burton (re-elected)
2nd District:	Dr. James Sidney Kitterman
3rd District:	Dr. J. Latane Ware
4th District:	Dr. Henry M. Snell (re-elected)
5th District:	Dr. Russell E. Herring, Jr. (re-elected)
6th District:	Dr. William E. Painter
7th District:	Dr. George E. Broman, Jr.
8th District:	Dr. Nicholas G. Colletti (re-elected)
9th District:	Dr. Robert V. Gailliot
10th District:	Dr. Richard L. Fields (re-elected)

Nominations for the State Board of Medicine were then received from the Third and Fourth Districts and the following names will be submitted to the Governor for consideration:

Third District

Dr. Edwin L. Kendig, Jr.
Dr. W. T. Thompson, Jr.
Dr. Custis L. Coleman

Fourth District

Dr. George J. Carroll
Dr. Charles H. Crowder, Jr.
Dr. Joseph Shermer Garrison, III

The Speaker then announced that the terms of Dr. William Hotchkiss and Dr. Michael Puzak as Delegates to AMA would expire on December 31, 1975. Both were re-elected.

The terms of Dr. John A. Martin and Dr. Carl E. Stark as Alternate Delegates were also announced as expiring on December 31, 1975. Both Dr. Martin and Dr. Stark were re-elected for 2-year terms.

Dr. Hill then officially installed Dr. Brown as the Society's new President.

Immediately following his installation, Dr. Brown presented Dr. Hill a special gavel and a Certificate of Distinguished Service.

Dr. Prominski requested and was granted permission to introduce a special resolution commending the Roanoke Academy of Medicine and the Program Committee of the Society for one of the finest annual meetings ever. The resolution also thanked the staff of Hotel Roanoke for the part it played in making the meeting a pleasant and memorable event. *The resolution was adopted.*

There being no further business, the meeting was adjourned, sine die.

ROBERT I. HOWARD, *Secretary*

APPROVED:

WILLIAM J. HAGOOD, JR., M.D., *Speaker*

General Session

A general session of The Medical Society of Virginia was convened at the Hotel Roanoke on Saturday, October 25, 1975. The session was called to order by Dr. William R. Hill at 6:05 p.m.

Dr. Wallace read those amendments to the By-Laws adopted earlier by the House and moved for ratification. *The motion was seconded and adopted.*

There being no further business, the general session was declared adjourned.

ROBERT I. HOWARD, *Secretary*

APPROVED:

WILLIAM R. HILL, M.D., *President*

* * * * *

From Peru to The Medical Society of Virginia's offices in Richmond travelled a Christmas greeting from Mario Ungaro, M.D., of Trujillo, Peru, with this hospitable message: "Dear friends, Please receive a Christmas greeting and a true desire that 1976 will be better than the year just finished! I am a professor of pathology in the Medical School of the University of Trujillo. Whenever one Virginian comes here, please let him know, and I will chaperone him." Dr. Ungaro's address in Trujillo: Avenue v. Larco 377.

Auditor's Report

We have examined the financial statements of the Medical Society of Virginia, Richmond, Virginia, for the year ended September 30, 1975, as listed in the foregoing table of contents. With the exceptions noted in the immediately following paragraph, our examination was made in accordance with generally accepted auditing standards for associations of this kind and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

The acounts receivable and accounts payable were not verified by direct confirmation; however, the amounts are not material in relation to the financial position as a whole.

It is our opinion that the Balance Sheet presents fairly the financial position of the Society at September 30, 1975, in accordance with generally accepted principles of accounting. The Statement of Income and Expenses is prepared on the basis of cash receipts and disbursements.

MITCHELL, WIGGINS & COMPANY
Certified Public Accountants

October 3, 1975

BALANCE SHEET

September 30, 1975

ASSETS

GENERAL FUND		
Cash in banks		$353,682.23
Accounts receivable:		
Due from members—Estimated collectible value—1974 Due	$ 2,570.00	
Advertising—Virginia Medical Monthly	549.00	3,119.00
		$356,801.23
BUILDING FUND		
Cash in bank		$ 50,000.00
Land and buildings—At cost	$113,723.67	
Furniture and equipment:		
Estimated value—October 1, 1950	$ 5,353.11	
Cost of acquisitions after October 1, 1950	15,512.44	20,865.55	134,589.22
		$184,589.22

NOTE: The accompanying notes to financial statements are an integral part of this statement.

LIABILITIES AND SURPLUS

GENERAL FUND		
Accounts payable:		
Preparation of Medical Journal—September 1975		$ 5,636.03
Deferred continuing medical education salaries		$ 1,096.08
Surplus:		
Available for appropriation:		
Balance—September 30, 1975		350,069.12
		$356,801.23
BUILDING FUND		
Surplus:		
Invested in tangible property		$134,589.22
Reserve for addition to building		50,000.00
		$184,589.22

STATEMENT OF SURPLUS

For the fiscal year ended September 30, 1975

GENERAL FUND		
Balance—October 1, 1974		$322,200.62
Add:		
Excess of income over expenses and transfers	$28,344.03	
Increase in accounts receivable	1,010.50	29,354.53
TOTAL		$351,555.15
Deduct:		
Increase in accounts payable		1,486.03
Balance—September 30, 1975		$350,069.12

NOTE: The accompanying notes to financial statements are an integral part of this statement.

STATEMENT OF INCOME AND EXPENSES

For the fiscal year ended September 30, 1975

		Actual	*Budget*
INCOME			
Membership dues	$326,174.03		
Less: Allocated as subscriptions to Journal	17,964.00	$308,210.03	
Interest on investments		30,309.98	
Virginia Medical Monthly:			
Advertising	$ 22,243.61		
Subscriptions:			
Members	17,964.00		
Nonmembers	732.45	40,940.06	
TOTAL		$379,460.07	

Expenses			
Salaries—General		$101,904.83	$105,000.00
Salaries—Continuing medical education	$ 19,011.34		
Less: Funded by Virginia Regional Medical Program	19,011.34		
Telephone		5,070.27	3,800.00
Postage		3,965.61	3,000.00
Stationery and supplies		5,665.42	3,500.00
Office equipment:			
Repairs and replacements		6,006.82	5,800.00
Building maintenance and repairs—Net		18,656.19	15,500.00
Convention expenses		11,518.82	8,000.00
Council and committee expenses		3,899.86	6,500.00
Travel:			
Executive vice-president		1,549.81	2,000.00
Executive assistant		637.67	600.00
Component society liaison		—	1,000.00
Delegates to American Medical Association		8,009.48	8,350.00
President's expense		2,382.98	3,000.00
Preparation and distribution of Medical Journal		57,662.14	50,000.00
Legal expense		26,810.06	15,500.00
Legislative program		6,113.92	6,500.00
Walter Reed Commission		500.00	500.00
Woman's Auxiliary		458.81	100.00
Membership dues—Affiliated agencies		480.00	730.00
Editor—Virginia Medical Monthly		1,000.00	1,000.00
Special appropriations:			
Virginia Council Health and Medical Care		5,000.00	5,000.00
American Medical Education—Foundation		1,000.00	1,000.00
Scholarship: Medical College of Virginia		2,000.00	2,000.00
University of Virginia		2,000.00	2,000.00
Eastern Virginia Medical School		2,000.00	2,000.00
Meeting—House of Delegates		1,695.01	—
Rural health		500.00	500.00
Insurance study		—	3,000.00
Bicentennial		2,000.00	2,000.00
Other special appropriations		1,811.22	750.00
Virginia Medical Political Action Committee		14,000.00	14,000.00
Newsletter		2,081.84	2,500.00
Employee's retirement fund		15,459.17	28,500.00
Payroll taxes		6,470.10	6,000.00
Public relations		903.91	1,000.00
Consulting services		5,000.00	—
Miscellaneous		1,902.10	850.00
Total Expenses		$326,116.04	$311,480.00
Transfer to Building Fund		25,000.00	25,000.00
Total Expenses and Transfers		$351,116.04	$336,480.00
Excess of Income Over Expenses and Transfers		$ 28,344.03	

Note: The accompanying notes to financial statements are an integral part of this statement.

NOTES TO FINANCIAL STATEMENTS

September 30, 1975

Note 1—A summary of significant accounting policies applied in the preparation of the accompanying financial statements are set forth as follows:

The Society employs a modified accrual method of accounting. General revenues are recorded when received, while interest on investments is recorded as earned. Expenses are recorded when paid without encumbrance of budget appropriations at the time liability is incurred.

Acquisition of property is recorded as capital outlay in the year purchased.

A general fixed assets group of accounts is maintained at cost and insurable value as shown in Building Fund Assets, with no depreciation being provided in the accounts.

Note 2—The Society has in force a noncontributory retirement plan covering employees qualified with retirement at age 65. The plan is administered by The Manufacturers Life Insurance Company, Toronto, Canada. The contribution during the current year amounted to $15,459.17.

BUILDING FUND ASSETS

September 30, 1975

Cash in Bank		
Southern Bank and Trust Company—Savings certificates		$ 50,000.00
Land and Building—At Cost		
4205 Dover Road, Windsor Farms, Richmond, Virginia:		
Land		$ 22,706.58
Office building		86,161.68
Furnishings and decorations		2,205.41
Lawn sprinkler system		2,650.00
Total Land and Building		$113,723.67
Office Furniture and Equipment		
Estimated insurable value at October 1, 1950		$ 5,353.11
Purchased subsequent to October 1, 1950:		
Cost during fiscal year ended September 30, 1951	$ 951.65	
Cost during fiscal year ended September 30, 1959	6,749.65	
Cost during fiscal year ended September 30, 1971	768.70	
Cost during fiscal year ended September 30, 1972	1,426.44	
Cost during fiscal year ended September 30, 1975	5,616.00	15,512.44
Total Office Furniture and Equipment		$ 20,865.55
Total Building Fund Assets		$184,589.22

FINANCIAL CONDITION

The financial condition of the Society at September 30, 1975, is shown in the balance sheet on the accrual basis of accounting. A comparative summary of the financial condition at September 30, 1975, and September 30, 1974, is presented as follows:

	September 30, 1975	1974	Increase Decrease*
Assets			
Cash	$403.682.23	$349,242.12	$ 54,440.11
Accounts receivable.	3,119.00	2,108.50	1,010.50
Land, building and equipment	134,589.22	128,973.22	5,616.00
Totals—All Funds	$541,390.45	$480,323.84	$ 61,066.61
Liabilities, Surplus and Fund Balance			
Liabilities:			
Accounts payable	$ 5,636.03	$ 4,150.00	$ 1,486.03
Deferred continuing medical education salaries	1,096.08	—	1,096.08
Surplus:			
General Fund	350,069.12	322,200.62	27,868.50
Building Fund	184,589.22	153,973.22	30,616.00
Totals—All Funds	$541,390.45	$480,323.84	$ 61,066.61

Cash—$403,682.23

Recorded cash receipts were accounted for by deposits in the various banks and disbursements were supported by properly signed and endorsed cancelled checks. The balances on deposit at September 30, 1975, were verified by direct correspondence with the banks and examination of certificates and passbooks on hand as follows:

General Fund:	
First and Merchants National Bank—Checking account	$ 9,513.27
Capital Savings and Loan Association—Certificates of deposits	5,714.46
Heritage Savings and Loan Association—Savings certificate	22,807.17
Heritage Savings and Loan Association—Savings certificate	144,710.82
The Peoples Bank and Trust Company of Richmond—Savings account	40,344.63
Bank of Virginia—Savings certificate	15,380.59
Southern Bank and Trust Company—Savings accounts	4,774.74
Franklin Federal Savings and Loan Association—Savings account	23,429.76
Richmond Federal Savings and Loan Association—Savings account	33,516.39
Security Federal Savings and Loan Association—Savings account	16,046.07
United Virginia Bank—Savings account	7,444.33
United Virginia Bank—Savings certificate	30,000.00
Subtotal—General Fund	$353,682.23
Building Fund:	
Southern Bank and Trust Company—Savings certificates	50,000.00
Total	$403,682.23

Building Fund—Tangible Property—$134,589.22

Details of tangible property are shown in a separate schedule. No indebtedness against these assets was disclosed by the records.

OPERATIONS

The results of operations for the fiscal year ended September 30, 1975, are shown in the statement of income and expenses prepared on the basis of cash receipts and disbursements. A summary of income and expenses of the General Fund for the current year is compared with the preceding year in the following tabulation:

	September 30, 1975	1974	Increase Decrease*
Income			
Membership dues—Net of subscription to Journal	$308,210.03	$304,498.42	$ 3,711.61
Medical Monthly publication	40,940.06	40,482.81	457.25
Other operating income	30,309.98	23,449.58	6,860.40
Totals	$379,460.07	$368,430.81	$ 11,029.26
Expenses	326,116.04	291,174.61	34,941.43
Excess of Income Over Expenses	$ 53,344.03	$ 77,256.20	$ 23,912.17*
Transfer to Building Fund	25,000.00	25,000.00	—
Excess of Income Over Expenses and Transfer	$ 28,344.03	$ 52,256.20	$ 23,912.17*

In General

The bookkeeping records were maintained in a satisfactory manner during the year.

Insurance in force at September 30, 1975, determined from policies on file, is shown below:

Fire and Extended Coverage	
Building—Windsor Farms, Richmond, Virginia—80% Coinsurance	$114,500.00
Office furniture and fixtures—80% Coinsurance	$ 16,000.00
Business Liability	
Bodily injury	$300,000.00—$300,000.00
Property damage	$300,000.00
Medical	$ 250.00—$ 10,000.00
Auto Liability—Nonownership	
Bodily injury	$100,000.00—$300,000.00
Property damage	$300,000.00
Medical	$ 250.00—$ 10,000.00
Workmen's Compensation	Standard
Employee Honesty Bonds	
Executive Secretary-Treasurer	$ 5,000.00
Secretary	$ 5,000.00



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- John B. Catlett, M.D.
- Robert W. Bedinger, M.D.
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- Burness F. Ansell, Jr., M.D.
- W. Wayne Key, M.D.
- Randolph M. Halloran, M.D.
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William D. Kernodle, M.D.

Editorials . . . .

On Doctor Harry Warthen's Retirement

AFTER TWENTY YEARS as Chairman of the Editorial Board of the *Virginia Medical Monthly*, Dr. Harry Warthen has retired. Since he and I have served contemporaneously on this Board, and longer than any other member, it was only fitting that I write the Editorial noting this unhappy event.

I could have described this tenure in vacuous generalities, but, lest my admiration for the man color my pen too much, like a professional historian I chose to revert to source material, his Editorials, all 206 of them, to get the measure of the man. This task, of no mean size, took the better part of three "reading-nights". But it was a task well worth the time: many of the Editorials were still as fresh as a friend seen yesterday; many needed renewal, like a friend last seen years ago; and alas, some had been totally eclipsed by the passage of two decades.

The content of these Editorials might be classified in this way:

	Number	*% of Total*
Socialized medicine and federal interference in the practice of medicine	46	22
Professional matters	27	13
Virginia Medical Monthly matters	25	12
History, medical and general	16	8
Encomia for the quick and the dead	16	8
Whimsy and humor	13	6
Paramedicals (nurses, etc.)	11	5
University of Virginia	11	5
Defence of the South	6	3
Local community and civic interest	6	3
Medical College of Virginia	5	2
Medical Society of Virginia	5	2
Medical Education	5	2
Malpractice	2	1
Miscellaneous	12	6
	206	

No question of Doctor Warthen's versatility. Technically, his sentences flow smoothly and he has a gift for the well turned phrase. One craftsman reviewing the work of another is likely to be more severe in his judgments than the ordinary reader. How many times did I say to myself as I was reading these essays: "Golly, I wish I could have written that". His paper about the disinterment of the lone Louisiana soldier found just outside Richmond ends with these words:

". . . Fortunately, however, he continues to be in the hands of friends and now he rests in the Confederate section of Hollywood Cemetery with 20,000 of his comrades.

May his sleep, henceforth, be undisturbed."

These words could have come only from someone of consummate sensitivity. But enough of Doctor Warthen as a craftsman.

Socialized medicine and government interference into medicine occupied most of Doctor Warthen's literary efforts as Editor. He foresaw the seriousness of the threat long before many of us were even aware of it. His denunciation and exposure of the shoddy, self-serving, pandering politician are joys to read, e.g., the "Hero of Chappaquiddick". With the terrible efficiency of a surgeon's scalpel he dissected the trappings away from the British health scheme and exposed it for what it is. The Swedish "Utopia" fared no better.

His love for Southern history becomes manifest in his many Editorials on the subject. Here, his erudition is most apparent. The greatness of a nation diminishes as its interest in its past diminishes, because only with this knowledge does a nation know where it is and where it is going. He regarded it as a mission to recall his beloved South's past, not only to its native sons but also to those of us who chose to adopt it as their home and who hope it to be their final resting place.

Doctor Warthen's whimsical and humorous editorials show another facet of the man. His account of the travails encountered in fetching champagne for his wife and her friend at a social gathering recall Benchley at his best. His discussion of the buxom lass's spiked heel as a lethal weapon, in terms of pounds of force per unit area, ranks not far behind his denigration of champagne.

As a clinician he was ever interested in nursing education and in the scarcity of the skilled bedside nurse, a subject comprising eight of his 11 essays on paramedical personnel. Because of his reasonable insistence that the prime purpose of a nurse is to help him take care of the sick, he has felt the sting of the nurse-educator, who is safely ensconced away from the bedside in a sweet-scented milieu issuing directives that affect the quality and supply of bedside nurses for time to come.

As a loyal alumnus of the medical department of Mr. Jefferson's academic village, he might be pardoned his prodigious output about its early Spartan beginnings to its present greatness. In contrast, the Medical College merited only half this output, and doubtless would have been even less, had there been no unhappy encounter between town and gown.

But Doctor Warthen achieves his finest in his role as apologist for the South against the calumnies of the Northern press, liberal politician, intellectual, artist and even the entertainment industry. My granddaughter is fascinated by a fine children's program on television, "New Zoo in Review" (to which I must confess my own addiction), in which one of the talking animals is Henrietta du Bois Ravenel Hippo, a frilly, charming, addle-brained, fat slob with a vaudeville "Southern" accent, whose major interest in life is her pecan-bearing confections. What a way to reinforce the stereotype in an impressionable audience. This virus that the South is an extrusion of Tobacco Road with its "red-necks" intent on the next lynching is of such a virulence that it has crossed the ocean to infect our English cousins. Many years ago, when British medicine was riding high, I was having tea with some members of the staff of a famous London hospital, without whose contributions over the centuries medicine would have been poorer. With a typically English genteel disbelief they heard me aver that in every Southern hospital that I had personal knowledge of, once the patient stepped over

the professional threshold color ceased to exist. American medicine for them consisted of New York and Boston in the east, a center or two in the mid-west and west, and Houston if one of the Royal house needed his aorta patched. And what was I doing, coming from a sleepy little town on the banks of the Rappahannock unknown to all but a military historian, with the temerity (and even effrontery) to sit for the Fellowship examination in their Royal College?

Doctor Warthen's skill as apologist is no better demonstrated than in his little piece entitled "Southern Living and Other Things", indeed my favorite of them all. Quotes will not do it justice. Comparison of the great homes of the North and of the South during the colonial and antebellum periods might help to explain "People hate up and never down". The sad recent events in Boston have shown our friends in the North that "morality" does not stop at the Mason-Dixon Line.

For reasons best known to himself, Doctor Warthen has let those who are more familiar with the Southern experience than any one else in the North escape the deadliness of his rapier: the intellectuals and writers who have left the land that gave them the day and who made it "big" in the North. Ignorance in others is an excuse, but not in this group who is neither ignorant nor stupid. And among this group can be found the most heinous vilifiers of them all.

I wish that medical education would have occupied more of his efforts, though he made several blasts at the paramedicals who try to enter medicine through the back door, such as some highly placed nurses and pharmacists. Favored treatment of minority groups for admission to medical school sat poorly with him, since this constituted discrimination in reverse. But he did have the perspicacity to suggest that Harvard, a big school, could better absorb such products.

How to sum up this man? Outrageous rarely, puckish often, readable always. He unabashedly loves his Country, his Southland, his profession and all those "square" virtues esteemed in an earlier, simpler day. And over the past 20 years he has raised his voice with a God-given fluency to stem the inexorable process of this Country's decay.

Doctor Warthen's successor has a lot to measure up to.

Christian V. Cimmino, M.D.

Erasmus

HOW DOES ONE account for the fairly obvious fact of superior average Jewish intelligence? Two explanations are evident. First, very likely the stupid Jews died out during the medieval persecutions, and the sharpest survived. Second, and this may be more important, the Jews allowed their smartest men, the rabbis, to marry and thus reproduce. The brightest minds in medieval Christendom went into the Church, but Christian churchmen remained usually celibate for a millenium and a half. The second argument takes some force from the example of Erasmus. His priest father remained unmarried and thus should not have reproduced. However, he bedded with his housekeeper, and his lack of celibacy resulted in one of the truly great minds of the Western World.

In our preoccupation with the present we tend to forget the intellectual leaders of five centuries ago, men who helped shape our present. Many of Erasmus' ideas were in advance of his times. We should remember him. He did influence medicine, both directly and indirectly.

He was born in Gouda, Holland, apparently in 1469, the son of "a minor priest and a lowly whore" as one of his later detractors remarked. His boyhood was exceedingly unhappy, so unhappy that he later liked to promote the fiction that he had been born in Rotterdam. His example confirms my opinion that if the genes are good enough the early environment does not matter too much. His bastardy was a lifelong source of embarrassment which his later prestige and moderate wealth never erased from his consciousness. His parents died of the plague in his youth. He entered an Augustinian monastery at Steyn while little more than a boy, became ordained a priest, and anticipated a lifetime as a monk. As he grew older he came to hate his narrow confines and narrow companions. He finally managed to pull a fast one. "More theological education is necessary for me to perform better my duties as an Augustinian," he piously said. Permission for him to leave to go to Louvain to study for a doctorate was grudgingly granted, and he got out, never to return. He wandered from city to city across Europe, at times to avoid a command to return to Steyn, at times just ahead of the plague, at times to seek education, and at times to seek professional advantage. He was in England several times. During his first visit there, when he became friend of the English humanists More, Colet, and Linacre, he instituted the teaching of Greek at Cambridge. Latin was almost a mother tongue to him; Greek he had taught himself in Paris. He saw Rome, Paris, Louvain, Basel.

When he was not traveling he studied intensely, not only theology but more especially the poetry, philosophy, and literature of the Ancients. He issued many editions of the classics. He translated the Greek New Testament into his familiar Latin. He wrote 12 to 16 hours a day standing at his lectern. He published sixteen million words in his incredibly industrious lifetime. Genius and perspiration seem to go together.

Erasmus did not confine himself to translation and study of the ancient writings. Indeed his other works are of more importance. His first, *Antibarberi*, was written in his youthful enthusiasm for the humanist approach to learning. He disdained the older scholasticism which emphasized rote learning of the Psalms and the writings of the Church fathers. He promoted history, philosophy, literature, the accomplishments of *man* rather than of *God*. His *Colloquia* gives a superb picture of the people of his time, from kings to peasants. His *Adagia* (adages) went through many printings. He was much interested in education and so he wrote a grammar, *A Method of Study*, and *On the Education of Boys*. He favored gentleness to, not the flogging of, pupils. His most famous work is his satire, *The Praise of Folly*. In addition, he was one of the most prolific letterwriters of all time.

Erasmus' ideas about education indirectly affected medicine. He was of moderate importance to medicine for other reasons as well. He wrote a good deal about his own illnesses. He had a myriad of complaints and ailments. His neglected boy's body became that of an adult hypochondriac. He had major illnesses as well. He was much afflicted by urinary calculi.

He had malaria often. A study of his exhumed bones has aroused the suspicion that he was syphilitic. (Was it acquired homosexually or heterosexually?) It is interesting to note that he strongly urged that persons afflicted with venereal disease not be allowed to marry. Through the years he consulted a great many physicians. Usually he was complimentary about the profession.

He studied the medical works of the Ancients. He wrote home-health books based on his studies of Hippocrates and Galen. Beyond such works his medical writings were minimal, and they were translations. Before me is the 1520 Basel edition of his translation and interpretation of a few of the "moral" essays of Plutarch. One essay is devoted to the precepts of maintaining good health by means of diet and the proper use of wine.

Even though his medical writings are of minimal importance his influence on medicine was certainly salutary. As the most famous leader of the humanists he promoted well the idea that man is not impotent, that he can change his own destiny, that he can improve himself. His emphasis was more on man and his works and abilities than on the iron will of a vengeful God. This humanist doctrine of Free Will was opposed bitterly by Luther. And to some Catholics Erasmus' ideas were heretical, especially since he pointed out many needed reforms. But he stayed safely away from Luther's domains and the sophisticated Popes of his day protected him from the Inquisition. He caused many men to disregard medieval scholasticism and look back to the Ancients, both medical and literary. He promoted always his advanced ideas of education. He pled for tolerance. He felt the bickering Catholics should come to amicable terms with the Protestants. His efforts were unavailing. At the end of his life, in the 1530's, he began to sense the impending onset of the ruthless wars of religion during which for more than a century Europe was laid waste, and men, women, and children were brutally killed in the name of the gentle Christ.

Gordon W. Jones, M.D.

Yet another honor for Samuel Newman, M.D., of Danville, this time a Resolution by Danville's City Council on the occasion of Dr. Newman's retirement from the post of clinician to the Danville Health Department:

Whereas, for more than fifty years Dr. Samuel Newman has served with distinction as the clinician in charge of the Pediatric Clinic conducted under the auspices of the Danville Health Department and has given of his time and efforts in promoting the Clinic to the success it has achieved today; and,

Whereas, upon his retirement from active duty at the Clinic, it is fitting and proper that the accomplishments of this great humanitarian be recognized by City Council;

Now, therefore, be it resolved by the Council of the City of Danville that the commendations and the especial thanks of a grateful community are extended to Dr. Samuel Newman upon his retirement as clinician of the Pediatric Clinic of the Danville Health Department in full recognition of the services he has rendered to the children of our City through his untiring efforts in the Clinic he sponsored and nurtured over the years in the interests of his fellow man.

Robert H. Clarke, *Mayor.*

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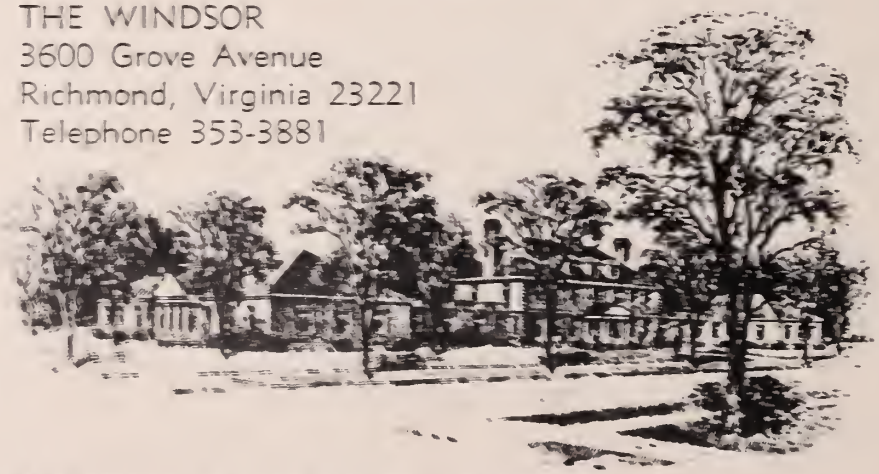
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Obituary . . . .

Nathan Bloom, M.D.
Richmond

Dr. Nathan Bloom died at his Richmond home on December 9, 1975. He was 71 years old. A graduate of the Medical College of Virginia's School of Pharmacy as well as its School of Medicine, Dr. Bloom taught at MCV, in addition to maintaining his private practice, becoming chief of the department of electrocardiography and professor of clinical medicine. He retired from his teaching responsibilities several years ago but continued his private practice in internal medicine and cardiovascular disease until his death. He had been a member of The Medical Society of Virginia since 1936 and was a fellow of the American College of Physicians. He is survived by his wife and two stepsons.

Henry F. Capozzella, M.D.
Oakton

Dr. Henry F. Capozzella, anesthesiologist, died November 8 at Oakton. He was 59 years old. Dr. Capozzella was a graduate of the Georgetown University School of Medicine.

James A. Gooch, M.D.
Alexandria

At the age of 71, Dr. James A. Gooch died October 24 in Alexandria. His specialty was internal medicine. He was a graduate of the Medical College of Virginia and had been a member of The Medical Society of Virginia forty years.

Frederick Bruce Forward, Jr., M.D.
Harrisonburg

Dr. F. Bruce Forward, Jr., was 41 years of age when he died in Harrisonburg on March 30, 1975. A specialist in family practice, he was an alumnus of the Medical College of Virginia.

Charles Hubert Bondurant, M.D.
Cobbs Creek

Dr. Charles Hubert Bondurant, a graduate of the Medical College of Virginia and a member of The Medical Society of Virginia for 45 years, died August 24 at Cobbs Creek. He was 70 years old. Dr. Bondurant began his practice in Bedford, later was with the Virginia State Health Department in Wythe County, and was on the staff of the Veterans Administration Hospital, Martinsburg, West Virginia, when he retired in 1971. His wife, two daughters, and a son survive him.

Sam Walter Huddle, M.D.
Rural Retreat

Dr. Sam W. Huddle, 62, died August 19 in Rural Retreat, where he had been a General Practitioner all his life and had served on the Town Council for 25 years. Dr. Huddle was a graduate of the University of Virginia School of Medicine and had been a member of The Medical Society of Virginia since 1938. His wife survives him.

William Harvey Huffstetler, Jr., M.D.
Newport News

Harvey Huffstetler died on January 10, 1975, following a 2-year battle with carcinoma of the colon. His struggle was a valiant one, and he will be sadly missed by the community in which he did General Practice for 25 years.

He was born on May 6, 1921, in Haw River, North Carolina. He attended Elon College and graduated from the Medical College of Virginia in 1945. Following internship at the Medical College of Virginia, he spent two years in the Army stationed at Fort Bragg, North Carolina. In 1948, he came to Newport News for two years of Ob-Gyn residency at Riverside Hospital, and remained here the rest of his life in General Practice.

Harvey had three big interests in life: his family, his practice, and fishing, not always in that order. The weather and what was biting seemed to have a lot to do with his priority.

He is survived by his wife, and three children, and by many friends who will always remember him best in his boat with fishing pole in hand.

Karl V. Gregg, M.D.
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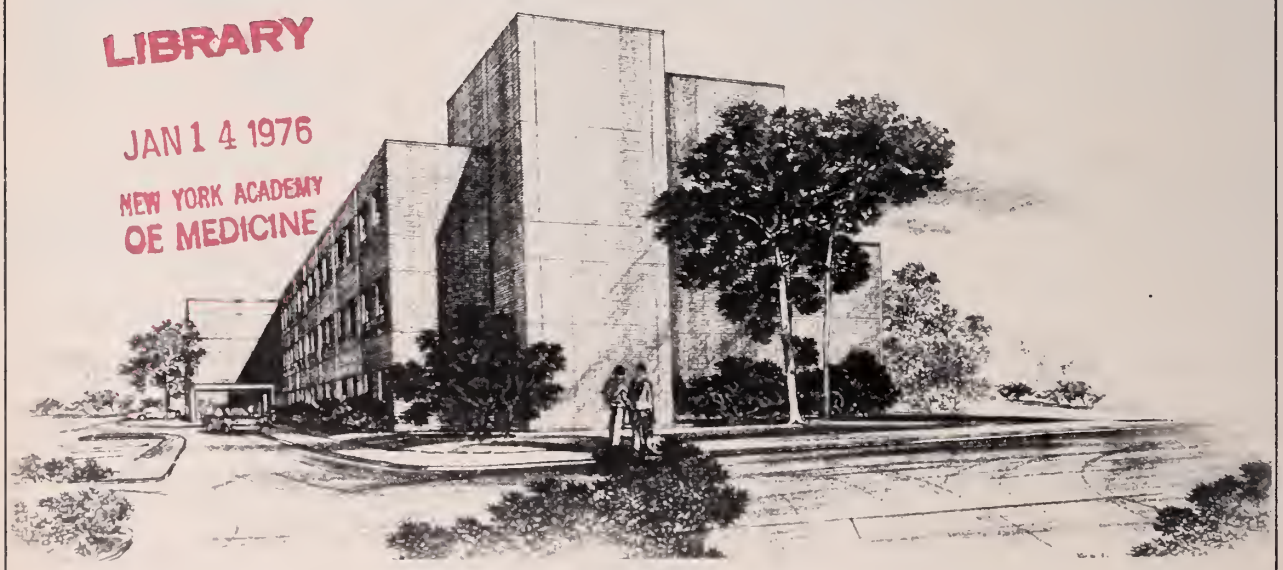
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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.
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Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.
Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.
Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)
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OFFICIAL PUBLICATION OF THE MEDICAL SOCIETY OF VIRGINIA

Vol. 103
FEBRUARY
1976

In this issue:

"How to Accredit a Medical Organization"

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major
ptoms, she is a psychoneu-
c patient with severe
iety. But according to the
cription she gives of her
ings, part of the problem
y sound like depression.
s is because her problem,
hough primarily one of ex-
sive anxiety, is often accom-
ied by depressive symptom-
logy. Valium (diazepam)
provide relief for both—as
excessive anxiety is re-
ed, the depressive symp-
s associated with it are also
n relieved.

There are other advan-
es in using Valium for the
nagement of psychoneu-
c anxiety with secondary
pressive symptoms: the
chotherapeutic effect of
ium is pronounced and
id. This means that im-
vement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) (IV)

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in psychoneurotic
anxiety states
with associated
depressive symptoms

veillance because of their predisposi-
to habituation and dependence. In
gnancy, lactation or women of child-
ring age, weigh potential benefit
inst possible hazard.

cautions: If combined with other psy-
tropics or anticonvulsants, consider
efully pharmacology of agents em-
yed; drugs such as phenothiazines,
cotics, barbiturates, MAO inhibitors
other antidepressants may potentiate
action. Usual precautions indicated in
ients severely depressed, or with latent
pression, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct nontherapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

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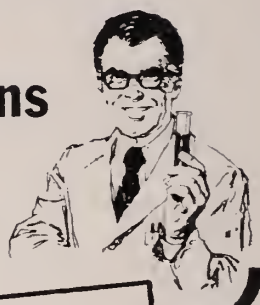
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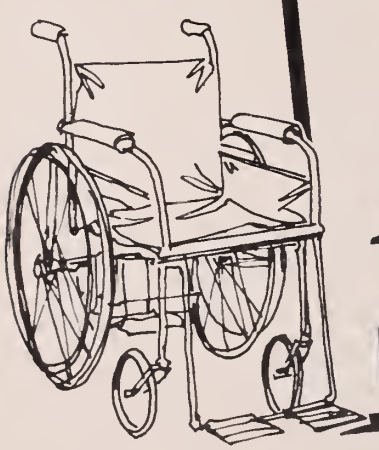
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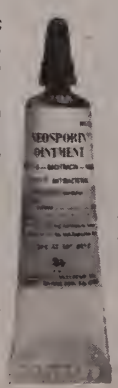
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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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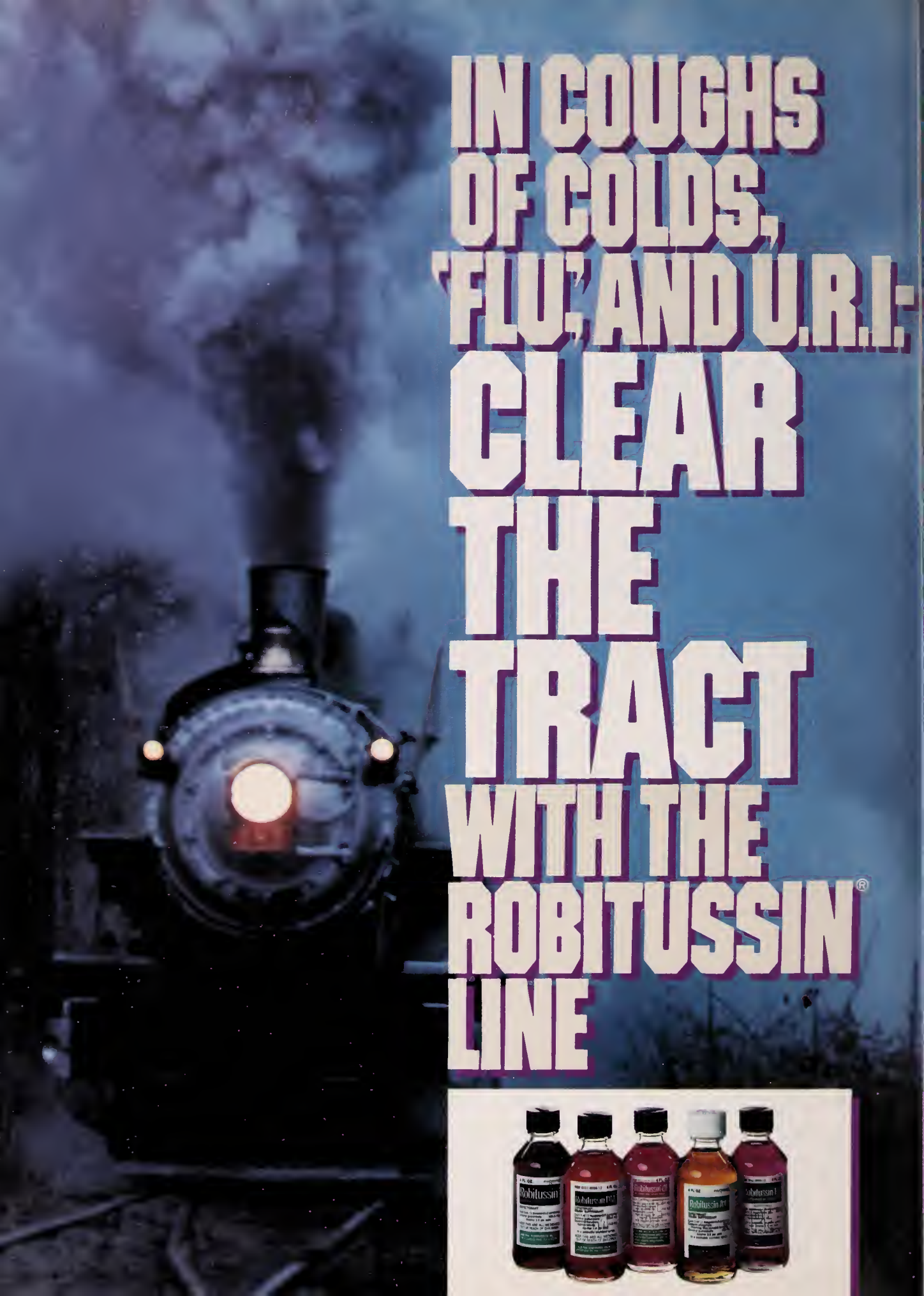
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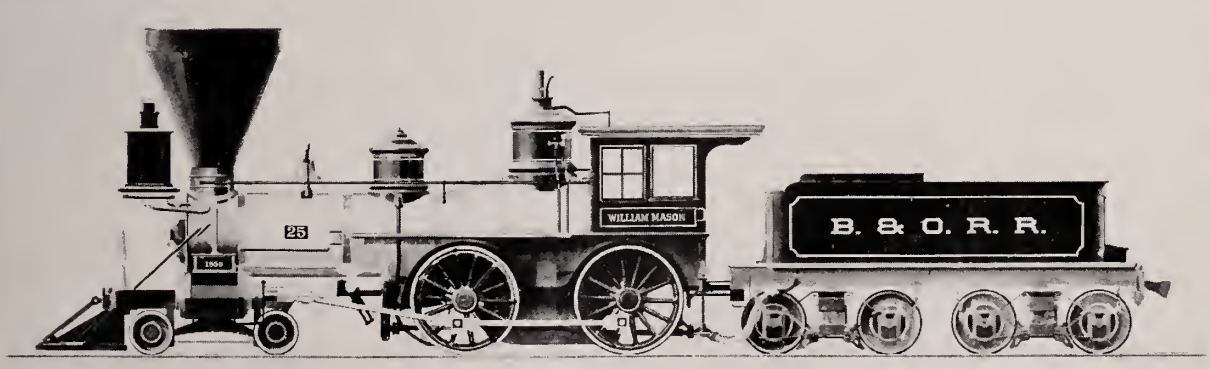
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Guest Editorials . . . .

G. B. Shaw on "Health Care Delivery"

HAVING BEEN ASKED to participate in a law school forum dealing with the economic aspects of health care, I set about preparing myself by reviewing some of the preselected reading assignments. Among those listed was an article by Nobel Laureate in Economics Kenneth J. Arrow.[1] It was a magnificent analysis of most available schemes for payment of medical care, expressed of course in pure "economicese," but included within was a reference to an old Chinese custom of paying physicians when well but never when sick!

I distantly recalled that George Bernard Shaw had once suggested the same sort of plan although I could not readily recall where. A brief search revealed it . . . his "Preface on Doctors" written as an accompaniment to the published version of *The Doctor's Dilemma*, Shaw's well-known satirical diatribe on medical pomposity and scientific fakery.

Once stimulated to reread his "Preface", I was treated to a veritable feast of Shavian commentary on the many facets of a topic which today's cliché users might refer to as "health care delivery." In addition, numerous caustic asides were directed toward the alleged purveyors of health care themselves. It was apparent to me that Shaw's "Preface on Doctors" ought to have been on the required reading list!

What follows is a sampling of Shaw's more amusing yet revealing comments. First, by way of background, it might be appropriate to recall that Shaw was an avowed socialist whose dramatic writings were specifically designed to provide his own brand of social commentary on the times. Thus *Man and Superman* dealt with the place of women in society, *Major Barbara* considers religious salvation, and *Mrs. Warren's Profession* serves as an economic analysis of modern day prostitution. Whether or not Shaw's views on medicine were in any way derived from his own personal experiences with illness remains in doubt and has been the subject of a previous discussion.[2] In any event, it is both amusing and revealing in this day of semi-informed medical dissent to consider George Bernard Shaw as he spoke out.

On medical economics:

"That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg is enough to make one despair of political humanity!" (Not recommended for quotation at your local Medical Society Meeting.)

On the germ theory of disease:

"We are left in the hands of a generation which, having heard of microbes as much as St. Thomas heard of angels, suddenly concludes that the art of healing could be summed up in the formula, 'Find the microbe and kill it.' "

On public health and preventive medicine:

"We already have in the medical officer of health, a sort of doctor who is free from the worst hardships and consequently from the worst vices of the private

practitioner. His position depends not on the number of people who are ill, but on the number of people who are well. He is judged as all doctors and treatments should be judged, by the vital statistics of his district." (He did have some heroes!)

On surgeons:

"The surgeon, though often more unscrupulous than the general practitioner, retains his self-respect more easily . . . the man who does evil skillfully, energetically, masterfully, grows prouder and bolder at every crime!"

On medical organization and efficiency:

"Men, whose dexterity as operators of almost divinatory skill in diagnosis is constantly needed for difficult cases, are out poulticing whitlows, changing unimportant dressings, and prescribing ether dreams for ladies with timid leanings toward dypsomania! In no other profession is the practitioner expected to do all the work involved in it from the first day of his professional career to the last as the doctor is. The judge passes sentence of death, but is not expected to hang the criminal with his own hands. . . . The bishop is not expected to blow the organ or wash the baby he baptizes. The general is not asked to plan a campaign or conduct a battle at half past twelve and to play the drum at half past two." (Amen, Brother!)

On socialized medicine:

"Until the medical profession becomes a body of men trained and paid by the country to keep the country in health, it will remain what it is at present: a conspiracy to exploit popular credulity and human suffering!"

On the medical cults:

"Everything that I have said applies equally to all the medical techniques, and will hold good whether public hygiene is based on the poetic fancies of Christian Science or the tribal superstitions of the druggist."

On disease:

"Remember that an illness is a misdemeanor and treat the doctor as an accessory."

And on life itself:

"Do not try to live forever."

Even though Shaw, if alive today, would probably not actively be sought as a featured speaker at an annual AMA Congress, nonetheless he would probably claim more listeners within the profession than he did at the time *The Doctor's Dilemma* was written. Was he a fool or prophet, mere satirist or health planner par excellence? Only the future will tell us how close to or far from exposing the genuine Achilles heels of medical practice he came.

Jack C. Fisher, M.D.

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Dr. Fisher formerly was Associate Professor of Plastic Surgery, University of Virginia Hospital, Charlottesville, and now is Head of the Division of Plastic Surgery, University of California Hospital, San Diego.

The Right To . . . .

THE ATTENTION of the nation was focused recently on Morristown, New Jersey, where for the first time the courts had been asked to grant permission to remove a patient from a respirator.

On April 14, 1975, Karen Anne Quinlan lapsed into a coma from which she has never recovered. An electroencephalogram is reported to have shown evidence of cerebral activity. Although Miss Quinlan is reported to have been able to ventilate "spontaneously for periods of up to half an hour", she has been on a respirator.[1] Her physicians have been quoted as saying that "Miss Quinlan would die within a week if her respirator were discontinued".[2]

Miss Quinlan's parents petitioned the Superior Court of Morris County, New Jersey, to allow them to order that their daughter be removed from the respirator since her physicians had refused to comply with their request.

Judge Robert Muir, Jr., ruled against the petition in November, stating in his opinion, "The nature and extent and duration of care is the responsibility of the physician."

Judge Muir should be highly commended for his decision. He has not, as the headlines have suggested, ruled that Miss Quinlan must be kept alive, rather that medical decisions regarding the course of treatment should be made by physicians, not by the courts. Judge Muir's decision in effect simply reaffirms the right and duty of a physician to choose the best therapy for his patient within those guidelines that have been established since the time of Hippocrates.

There is no question that a rational, competent, and fully informed patient may choose not to follow his or her physician's advice. When the patient is not mentally competent, as in the case of Miss Quinlan, then the attending physician must have the right to choose appropriate therapy until and unless he is dismissed or resigns from the case and another competent physician is placed in charge.

"Appropriate therapy" in the setting of cases similar to Miss Quinlan's should not be taken to suggest that there is any uniformly applicable course. Benign measures to produce patient comfort are as important and as recognized a form of therapy as heroic efforts utilizing all the sophisticated life support systems presently available. The right to choose as reaffirmed by Judge Muir is with the attending physician; the sole prohibition is that he not actively cause death.

EMIL J. KLEINHOLZ, JR., M.D.

2621 Grove Avenue
Richmond, Virginia

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2. Times-Dispatch: November 11, 1975, page 1.

Special Article . . . .

To Tell or Not to Tell, a Physician's Dilemma

HAROLD L. HIRSH, M.D., J.D.
Washington, D. C.

A CURRENT national concern is the malpractice crisis. A review of materials presented at meetings, conferences, seminars, and in the literature reveals that there is a complete preoccupation with the physician's liability to the patient, with little thought given to his potential liability to third parties. In the past, physicians have been held legally liable by the courts when they failed to relay necessary information and a third person has been harmed.[1] This legal doctrine imposing a duty on the physician to adequately and appropriately warn, is applicable to the practice of medicine whenever it is part of the physician's professional responsibility to give information involving a person's safety. This includes patients and third persons, who may even be strangers but in dangerous proximity to them.

The courts have imposed a duty on physicians to inform patients and third parties of the potential danger of a contagious disease.[2] In four reported cases physicians were held liable in negligence to third parties for failing to identify tuberculosis,[3,4] smallpox,[5] and scarlet fever[6] patients, and also to warn as to the hazards of their contagiousness and communicability. These third parties either suffered severe medical consequences or died from these diseases after continuing close contact with the patients.

The courts have, by indirection, recognized a physician's duty to warn a third party regarding the communicability of a patient's contagious disease. The Nebraska Supreme Court held[7] that the physician's conduct was a justifiable effort to protect others in resolving a suit by a patient against the physician for invasion of privacy. The defendant physician had taken it upon himself to advise the patient's landlady that the patient might have a contagious disease (syphilis) and that she should be careful to disinfect the patient's bedclothing and to wash her hands in alcohol afterwards. Acting upon this warning, the landlady removed all of the patient's belongings to a hallway and fumigated his room. It is obvious that the law cannot reasonably require a physician to keep silent while one of his patients acts irresponsibly or unwittingly exposes others to a risk of infection or some other harm or injury.

In another case,[8] a physician was sued by an injured passenger for failing to advise a bus-driver-patient of the sedative effects of an antihistamine. Another physician was sued[9] by a pedestrian because he failed both to ascertain completely the nature of a patient's seizures and advise the patient of the hazards of driving. The patient had lost consciousness and control of the car while having a seizure and struck the pedestrian, causing injuries.

Another aspect in which a physician was held liable to a third party is demonstrated in the following case.[10] An automobile driver who accidentally injured an individual was allowed to seek indemnity from the physician who negligently treated that individual as a patient and aggravated the patient's injuries. The patient had brought an action for damages against the driver, and the driver instituted a third-party lawsuit against the patient's physician. In the suit, the driver alleged negligence on the part of the physician, resulting in aggravation of the injured individual's condition. The court held that since the driver was responsble for all damages flowing from the accident, including the physician's negligent treatment, he could seek indemnification from the physician as to the injuries allegedly caused by the physician. In regard to the physician's negligence, the driver was declared not actively negligent and could seek

indemnification from the physician to the extent of the latter's negligence.

A review of this medical-legal problem was undertaken because recently the family of a murder victim was awarded damages for malpractice liability against a psychiatrist and his employing institution for failure adequately to warn of a suitor's intention to murder the victim. The suitor-patient had stated this intention two months earlier during a therapy session. The court concluded[11] that a physician or psychotherapist treating a mentally ill patient, just as a physician treating a physical illness, bears a duty to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from his patient's condition or treatment. If the potential victim cannot be reached, persons who might reasonably be expected to convey the message, such as relatives or the authorities, should be notified.

This decision is in accord with several verdicts in recent years holding a health care provider liable to a third party for failing adequately to warn of the dangerous propensities of a patient.[12] In the most recent case,[13] the federal government was held liable for the wrongful death of a wife of a psychiatric patient who had been allowed to leave a Veterans Hospital on a work-release basis. The protesttations and fears of the wife prior to the patient leaving the hospital were ignored. The employer was erroneously informed of the patient's diagnosis and was not advised of his dangerous propensities. No precautionary measures were arranged. Letters to the institution from the patient while on leave indicating continuing delusional ideas were ignored.

In two New York cases,[14,15] the courts held that an injured third party could bring a cause of action against a physician if he had been injured by a patient with dangerous propensities due to mental problems when the physician failed to warn the third party. The court noted, however, that the plaintiff would have to establish that the physician knew or should have known of the dangerous propensities. In any event, this would be a question of fact for the jury. These court opinions do establish the duty of a physician to warn persons other than the patient of the possibility that the patient may pose a danger to such third parties.

A decision in California has created new concern among physicians. They contend that it compromises the physician-patient relationship, which imposes a professional, ethical, moral, and legal duty on the physician to protect his patient's privacy and confidentiality.[16,17] Further, it has raised the spectre of liability based on retrospective judgment, which is immensely different from a prospective judgment. There is also the question of where the duty to warn begins or ends. And what if a patient threatens a whole community, or people of a certain race, ethnic or religious groups, or members of one of the sexes? Physicians are troubled by a court's language which demands that they make a subjective evaluation when a patient indicates he might do injury.

An answer to this dilemma is found in our judicial system, which recognizes a physician's professional discretion not to reveal information, if, in his judgment, it is undesirable or unnecessary.[18] Further, the physician can protect himself by making an appropriate entry in the patient's record. Even if the failure to disclose is later proven to have been a mistake, this will be considered an error in judgment, and not negligence, so that the physician is not legally liable. There are many times when the interests of the individual come into conflict with the rights of the public, and the physician must decide between these rights, and compromise the patient's right for the benefit of the public.

The criminal liability of the health care provider for failing to report certain diseases or activities as required by law (such as contagious diseases, injuries due to criminal activities or accidents, the battered-child syndrome, and similar situations) is well established.

The law has imposed strict liability for injuries caused by their products on the manufacturers of food, drugs, and dangerous instruments. The cases that are noted represent an extension of this strict liability doctrine to health care providers. This is in concert with

the increasing awareness and recognition that a physician has the responsibility to identify any reasonable foreseeable harmful situations.[19]

Physicians should recognize that in caring for some patients they also acquire legal duties to third parties. Specifically, physicians should consider their obligations to potential third-party victims of patients with such conditions as coronary artery disease, cerebral arteriosclerosis, diabetes mellitus, and other medical conditions. To be practical, a physician will satisfy his responsibilities if he reveals only that information he believes to represent a clear and present danger to the public.

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(For more on malpractice, turn to page 153.)

Dr. W. Taliaferro Thompson, Jr., Named Editor

Dr. Raymond S. Brown, MSV President, in concert with the Editorial Board, announces the appointment of Dr. W. Taliaferro Thompson, Jr., Richmond, as Editor of the *Virginia Medical Monthly*, to succeed Dr. Harry J. Warthen, who becomes Editor Emeritus.

Dr. Thompson is a native Virginian and graduated from the Medical College of Virginia in 1938. He trained in internal medicine in Boston, served with the 45th General Hospital (Medical College of Virginia unit), and returned to Richmond to take up the practice of medicine. In 1954 he became Chief of the Medical Service at McGuire Veterans Administration Hospital. In 1959 he was named the William Branch Porter Professor of Medicine and Chairman of the Department of Medicine at the Medical College of Virginia, a position he held until 1973, when he relinquished the chairmanship. He was named Emeritus Professor in 1975 and continues to be active in many medical affairs.

Dr. Thompson's greeting as Editor is on page 162.

Yes, Virginia, There Is a Buerger's Disease

LEVI OLD, JR., M.D.
THOMAS LANE STOKES, M.D.
Norfolk, Virginia

Buerger's disease is of unknown etiology, but its occurrence in heavy smokers suggests that tobacco may play a causal role. A characteristic clinical, histopathologic, and arteriographic picture differentiates this syndrome from arteriosclerosis or embolism.

IN RECENT years doubt has been expressed in some quarters that thromboangiitis obliterans, Buerger's disease, actually exists. This brief presentation is offered in the belief that there really is a Buerger's disease.

Von Winiwater, in 1879, described a condition of endarteritis and endophlebitis. Not until 1908, however, did the classic description of thromboangiitis obliterans appear. In that year, Leo Buerger, New York surgeon and pathologist, gave such a complete and accurate report of the condition[1] that it soon took on his name, becoming widely known as Buerger's disease.

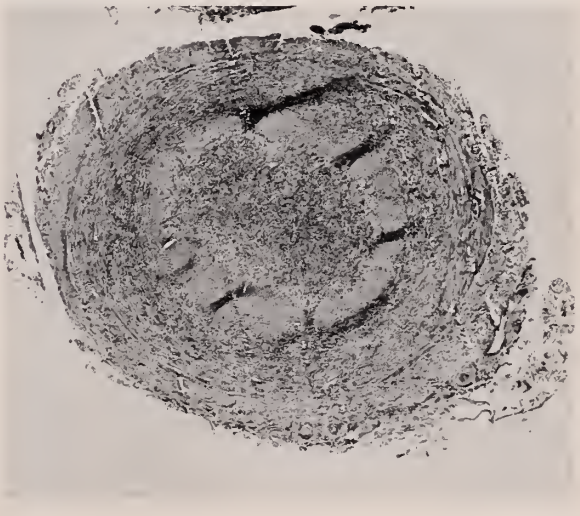
It is interesting to note that even as Buerger, a man of varied interests, was preparing the article, he was also deeply engrossed in problems of urology. In 1909, he added a lens system to the Brown cystoscope, thus creating the widely used Brown-Buerger cystoscope. In 1924, his book[2] devoted many pages to thromboangiitis obliterans, further popularizing knowledge of the disease.

The precise etiology of thromboangiitis obliterans remains unknown. It develops primarily in males under 35 years of age. They are not predominately Jewish, as was at first believed. The victims are almost without exception heavy smokers. Possibly, Buerger's is an allergic vasculitis due to nicotine. In many patients the arms as well as legs are affected. Other common characteristics are a migratory thrombophlebitis and extreme pain, apparently more severe than in other vascular diseases.

The clinical manifestations of ischemic pain, acute superficial phlebitis, sensitivity to cold, diminished pulses, and dependent rubor may lead to the classic presenting picture of distal digital necrosis.

Buerger's disease affects the medium and small arteries and veins of the lower extremities, and sometimes of the upper extremities, by a segmental, nondiffuse, inflammatory thrombosis with panarteritis or panphlebitis without actual suppuration. This organic blood vessel obstruction, of course, leads to impaired blood flow. Only rarely are visceral vessels involved.

Pathologic studies as shown in the photomicrograph below illustrate the general architecture of the vessel preserved and the lumen filled with highly cellular organizing



Presented at the Muller Surgical Society Meeting, University of Virginia Medical Center, May 22-24, 1975.

and recanalizing thrombi. The media and adventitia exhibit a lymphocytic infiltrate above the vasa vasorum. The adventitia is fibrotic.

The differential diagnosis is primarily with arteriosclerosis, although consideration should include such possibilities as Raynaud's disease, scleroderma, gout, leprosy, frostbite, entrapment, and hypercoagulability. So far as hypercoagulability is concerned, Buerger's is considered a disease of the blood vessels rather than one of the blood itself.

In contradistinction to arteriosclerosis, there is no association with diabetes, hypercholesterolemia, or embolism.

Short of tissue histologic study, the best diagnostic consideration comes from arteriography, which gives a clearly different picture from that of arteriosclerosis, as shown in Table 1.[3]

Table 1.—Arteriographic Distinctions Between Buerger's Disease and Atherosclerosis

Aspects	Buerger's Disease	Atherosclerosis
Size of arteries involved in the disease process	Small and medium	Small, medium and large
Upper versus lower extremity involvement	Both upper and lower extremities	Lower extremity predominantly
Extent of occlusive changes	Segmental	Diffuse
Character of artery proximal to site of occlusion	Smooth-lined vessel of even caliber	Irregularities in the intima and caliber of vessel
Appearance of collateral circulation	Tree roots configuration of vessels around point of abrupt occlusion	Not specific
Evidence suggesting atheroma in larger vessels	Absent	Present

Patients with Buerger's disease absolutely must stop smoking. Otherwise, as in all conditions with a nonspecific etiology, the treatment is basically symptomatic. Good care of the extremities is important. Long term anticoagulants and steroids are of little proven value. Vasodilator drugs are likewise of doubtful efficacy. At present niacin is being advocated. Surgical sympathectomy is often tried. Amputation should be deferred as long as possible.

Buerger's disease was a routinely accepted condition until 1960, when an article by Stanford Wessler and associates[4] of the Beth Israel Hospital in Boston stirred up a controversy. McKusick answered Wessler by citing his studies of cases in the Orient.[5] There he had found classic clinical, arteriographic, and histopathologic Buerger's disease without much arteriosclerosis or embolism. McKusick reemphasized "The site of the acute primary alteration is in the thrombus itself rather than in the vessel wall."

McKusick made a classic statement in 1962: "If the patient with true Buerger's disease continues to smoke, one can predict progression of his disease with a certitude rare in medical prognosis. Contrariwise, one can with about equal confidence predict to the patient that his disease will not progress significantly if he will stop smoking completely."

The following case report presents evidence of the existence of Buerger's disease. A 34-year-old white non-Jewish male, a heavy smoker and an aircraft parts salesman whose job necessitated frequent moves, was seen in December, 1960, with an ischemic painful right toe. After his evaluation (including arteriography) suggested Buerger's disease, a right lumbar sympathectomy was done. He was strongly advised to stop smoking.

In October, 1961, Victor McKusick, M.D., agreed with the diagnosis of Buerger's disease, and the Johns Hopkins surgeons did right second toe amputation. But after the patient returned to Norfolk, more surgery became necessary.

Feb., '63: Right thoracic sympathectomy
Jan., '65: Right middle finger amputation
Aug., '65: Left thoracic sympathectomy
Left middle finger amputation
Left ring finger distal amputation.

Then, the patient's job carried him to New Orleans, where further operations were done.

Nov., '65: Left lumbar sympathectomy
July, '66: Left middle toe amputation
Left below knee amputation
Aug., '66: Right transmetatarsal amputation
Right below knee amputation.

His final move before returning to Norfolk was to Palm Beach in 1967, where additional amputations were performed.

Nov., '67: Right little finger amputation
Left little finger amputation
Multiple bilateral finger amputations
Mar., '72: Left wrist amputation
Apr., '72: Right wrist amputation.

Therefore, as shown in the views on this page, despite adequate bilateral elbow arterial pulsations and bilateral knee area arterial pulsations, the patient ended up with bilateral distal forearm amputations and bilateral below-knee amputations.

Now, in 1975, he is back in Norfolk. He says that he has "almost stopped smoking" and that the Florida physician's prescription of niacin is helpful. Current examination shows that his thromboangiitis is basically quiescent. He has no symptoms of visceral Buerger's. He has four well functioning prostheses, a motorized wheelchair, and a specially equipped automobile van.

In summary, a small number of patients with vascular disease exhibit a clinical, arteriographic, and histopathologic picture not typical of arteriosclerosis or embolism. Despite unproven etiology, this syndrome constitutes a distinct entity which has come to be known as thromboangiitis obliterans, or Buerger's disease.

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These four figures show the patient after the documented operations. Top view, upper limbs amputated above the wrists and lower limbs amputated below the knees. Above, close-up view of bilateral distal forearm amputations. Below, in his motorized wheelchair, with prostheses fitted to all four amputations. Left below, close-up view of forearm prostheses.



Acute Head Injury

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A course is charted for prompt and logical management of acute head injury. The necessary studies must be obtained with dispatch and possibly harmful procedures avoided. Then treatment can be given before there is irreversible damage.

THE PROBLEM of head injury to the practicing physician or to the intern in the emergency room has seemed to this neurosurgeon to present such confusion that an attempt to simplify the chaos might be appropriate despite numerous articles[1,2] and textbooks which have seemed only to add intricacy rather than simplicity to the issues involved. There are first and foremost several distinguishing points of prime importance:

1. Patency or adequacy of airway
2. "Shock" or its absence
3. Level of consciousness of patient
4. Associated or multiple injuries
5. Neurologic assessment after 1-4 have been evaluated
6. The requisite radiologic studies necessary for immediate further assessment of injuries and proper immediate care
7. Ancillary adjunctive studies such as arteriography and pneumoencephalography

In any patient with head injury who, for any reason, has an inadequate airway with accumulation of secretions and bloody mucus, the insertion of an endotracheal tube or tracheostomy may prove a life-saving measure. No time should be lost in instituting one or the other measure, and every intern should be taught the mechanics of endotracheal intubation by an anesthesiologist early in his intern career. If time permits it is best to perform tracheostomy in the operating suite, where adequate illumination and assistance may be better available. Tracheostomy is most assuredly not a simple procedure, and observation of the performance of several of these with later supervision is desirable. Once an airway has been presented to the unconscious patient the next steps become rather obvious. If the patient is semicomatose or deeply unconscious the status of pupils, presence of spasticity or flaccidity of limb(s), response to painful stimulation (supraorbital pressure, pinching of the pectoral region severely, and painful stimulation of the sole of the foot), bleeding from ears, nose, or mouth (presence of CSF), may prove helpful lateralizing signs. The presence or absence of decerebrate rigidity should be noted at this time.[3] If the patient is merely drowsy, amnestic, confused and a change in the level of his sensorium with deterioration occurs, the neurosurgeon should be immediately alerted. If the patient is in shock with no external, obvious sign of blood loss, the physician should be immediately concerned with injuries other than those of cranial origin alone. Chest, abdominal, pelvic, and long bone injuries may frequently accompany the intracranial injury and produce the picture of shock. A word of advice relative to roentgenologic studies is very much apropos at this point. Patients with possible critical injuries are only too often moved, transported, and shifted into all manner of positions for the purpose of innumerable, sometimes unnecessary, and occasionally disastrous, xray studies. The unconscious or semicomatose patient should not be sent to the xray department without a physician in attendance. If skull

films are to be obtained, a portable lateral cervical spine film should first be obtained and read before proceeding with the necessary skull studies. Subluxations of the cervical spine may be otherwise readily overlooked, with serious later portent to the patient. In the muscular or obese patient with a short neck, an oblique portable cervical spine film may often be of great assistance.

Multiple injuries which may have occurred to chest, head, abdomen, or long bones and pelvis necessitate the expertise of neurosurgeon, surgeon, thoracic surgeon, and orthopedist. Alerting each of these specialists simultaneously will often preclude hours of delay and permit performance of operative procedures concomitantly and expeditiously.

Recognition of the possibility of intracranial or intracerebral hematoma before the development of cerebral decompensation, uncal or tentorial herniation and irreversible decerebrate rigidity, can be a very significant factor in eventual salvageability of the patient. Surgical mortality in head injury patients has been shown, beyond any possible doubt, to increase as diagnosis is delayed and with the prolonged duration of the decerebrate state.[4] Although the decerebrate condition in head injury patients has notoriously indicated a very grave prognosis, early surgical intervention may significantly alter these statistics for the better.

The intern in calling upon the neurosurgeon should be prepared to answer the following questions before any xray studies have been obtained. Is the patient a child, adult, or elderly person? Is the patient drowsy, semiconscious, or comatose? Does the patient respond to verbal, painful, or only the most excessively painful stimulation, or not at all? Is speech repetitive, confused, and is patient amnestic? Are pupils small, large, equal, unequal, reactive to light? Is shock or borderline shock syndrome present? Any associated injuries evident? If patient is semicomatose or comatose, do any extremities respond to painful stimulation, and if so, which—upper, lower, unilateral, etc.? What are blood pressure, pulse, respirations? (These should have been obtained quickly by nurse or attendant at time of admission of patient.) Alcoholic ingestion, while of passing interest, is not helpful and may often lead the unwary to deceptive conclusions. Is there evidence of CSF leakage from nostrils, mouth, or ears? (Blood may often appear of "watery" consistency.) Preparation of adequate responses to these few queries may be of infinite importance to the neurosurgeon whose assistance is requested and may enable him to plan his mode of attack on the problem prior to his coming to the hospital. He may prefer on the basis of such information:

1. To admit the patient to the hospital floor or to intensive care unit for further observation,
2. To consider advisability of immediate arteriography,
3. To take the patient immediately to the operating theater for surgery.

Dependent on his decision, xrays may have been taken, the head of the patient shaved, xray and surgery teams notified, and all avoidable delay be disposed of prior to arrival of the neurosurgeon and other members of the surgical team.

Depressed skull fractures are easily diagnosed by palpation of the skull if there is an open laceration; otherwise, dependence must be placed upon the skull xrays, since palpation over a scalp hematoma is totally unreliable. Bleeding from the ears, nose, or mouth in the absence of direct trauma to these structures is almost always pathognomonic of basilar skull fracture. Xrays of the skull will most frequently fail to reveal these fractures and should therefore be disregarded, unless a fracture is noted or unless fluid-air levels should occur in the sphenoid sinus.

Brain scans are rarely to be utilized in the acute head injury patient because of time involved, the possible critical state of the patient and the need for urgency, and the presence of scalp trauma, which will often yield false positive results. Lumbar puncture is of little assistance and may prove quite dangerous. Echoencephalography may also be unreliable, especially where bilateral subdural clots are

present and could well lead the examiner into a sense of false security. Arteriography remains the single most valuable diagnostic tool short of direct exploration. Bilateral carotid arteriograms should be made (since the clot may be bilateral, or clot may be present on one side and intracerebral, contrecoup hematoma may occur in the opposite hemisphere); in experienced hands this procedure can be performed within 30-45 minutes of operative time. If surgery is indicated the patient may be immediately transported to the operating suite for definitive treatment. If no surgical lesion is present and cerebral edema as demonstrated by vasospasm, or failure of filling of one or both carotids intracranially above the siphon becomes manifest, management of the patient is made somewhat easier and prognostic explanations to the family of the patient simplified. Thrombosis of a carotid artery in the neck secondary to trauma, although rare, may quite obviously be elucidated by this technique. Another great advantage is that aberrant subdural hematomas will not be overlooked, as may happen when routine "burr holes" are made in search of acute subdural or extradural hematoma.

The most common errors of judgment noted over the years seems in my experience to be the following:

1. No fracture is noted on the xray films and no objective neurologic findings are noted; the patient may be discharged with later disastrous results.
2. Patient is believed to have papilledema after head injury; this is so rare as almost never to occur.
3. Subluxations of the cervical spine are easily overlooked because no thought has been given to obtaining an xray film.
4. The patient is either not disrobed, or incompletely, so that other injuries are missed.
5. So much attention is focused upon one injury, head vs. abdominal, that the patient expires from a ruptured spleen, lacerated liver, or ruptured duodenum.
6. Unnecessary xray procedures, while valuable time is lost in treating the patient for the most pressing condition, may contribute to his demise.
7. Confusion of a "stroke" in the elderly with acute subdural clot, or attributing stupor and confusion to alcohol, when a clot may be present.
8. Failure on the part of admitting physician or nurses to note progressive but gradual deterioration of the head injury patient with too late consultation with neurosurgeon.
9. A tendency to regard an injury as "minor", when no true minor head injury exists.
10. Inadequate or absent history: diagnoses of meningitis, encephalitis or encephalopathy, "stroke", etc., when the actual pathology is that of subdural hematoma and appropriate treatment should be promptly instituted.

There are numerous occasions when direct surgical exploration becomes imperative because of paucity of time and the extreme critical condition of the patient with rapid and impending intracranial decompensation. This factor of head injury makes the role of the intern in the emergency room or that of the referring physician such an important one. Loss of life may well be related to dilatory, procrastinating, or careless efforts on the part of either. Perhaps this may truly represent one of the cardinal motives in presentation of this brief paper.

"Burr holes" are usually placed in the temporal areas, and usually bilaterally in the case of subdural hematoma (since there is a 50% or better probability of bilateral clot). Additional openings may, of course, prove necessary. The author believes that the following conditions have led to failure of survival of the patient in most instances:

1. Late diagnosis of the lesion with increased morbidity and mortality
2. Associated brain injury (severe contusion, laceration, or brain stem injury)
3. Incomplete removal of clot: in many instances, a large "flap" type procedure is preferable to multiple burr holes
4. Failure to recognize an "aberrant" clot (such as may occur in posterior fossa extradural hematoma)—removal of the supratentorial clot proves of necessity insufficient
5. Failure to control *all* bleeding points at the time of initial surgery, with subsequent reformation of clot
6. Failure of the brain to expand at the time of surgery, leading to 5. above

7. Massive cerebral edema with brain herniation at time of surgery or subsequent to surgery

Summary

A concise outline has been presented of the problems, diagnosis, and essential management of acute head injury problems for assistance to nurse, emergency room intern, and general practitioner with the intent that by its very simplicity some of the mystery and, at times, overwhelming uncertainty in dealing with the acute head injury syndrome may be somewhat dispelled.

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What's YOUR Specialty, Doctor?

Surgery is the largest category of specialty within The Medical Society of Virginia's membership, a recent analysis reveals. There are 915 members who practice as surgeons, this out of the total of 5,118 physicians on the membership rolls in mid-December, 1975.

General practice is the second biggest group, with 741 members giving this as their specialty. Internal medicine, claiming 593 members, is the third largest specialty.

Here are the complete results of the poll:

Surgery	915
General practice	741
Internal medicine	593
Obstetrics/gynecology	374
Pediatrics	364
Psychiatry	332
Radiology	245
Anesthesiology	213
Ophthalmology	208
Family practice	183
*Diseases	154
Pathology	153
Otorhinolaryngology	113
Dermatology	76
Public health	74
Neurology	55
Emergency medicine	33
Occupational medicine	33
Gastroenterology	24
Allergy	21
Rheumatology	18
Physical medicine/rehabilitation	16
Hematology	11
Nephrology	11
General preventive medicine	8
Geriatrics	8
Nuclear medicine	8
Aerospace medicine	5
Endocrinology	5
Clinical pharmacology	3
Legal medicine	2
Hypnosis	1
Laryngology	1
Nutrition	1
Other	73
Unspecified	43

*Cardiovascular, pulmonary, neoplastic, and infectious diseases, and diabetes.

Within the leading category of surgery, these were the subspecialty totals shown: general, 447, orthopedic, 194; urological, 120; neurological, 63; plastic, 34; thoracic, 24; cardiovascular, 11; colon/rectal and abdominal, 7 each; hand, 4; pediatric, 3; head/neck, 1.

In addition to the physicians in the analysis above, there were in mid-December 236 student members of the Society, for a complete membership total of 5,354.

Carpal Tunnel Syndrome

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THE TERM "carpal tunnel syndrome" encompasses all conditions which produce irritation of the median nerve within the carpal tunnel. This entity and its association to the volar carpal ligament was first described in 1913 by Marie and Foix.[1] However, its clinical importance was not recognized until it was redescribed in 1950 by Phalen.[2] Since that time, it has come to be known as the most common single cause of pain, numbness, and tingling in the hand.

The characteristic clinical findings of this syndrome are: (1) Night pain in the wrist area, severe enough to disturb sleep and usually associated with numbness and paresthesias. (2) Positive Tinel's sign, a tingling sensation produced by lightly percussing the median nerve at the wrist. (3) Positive flexion test (Phalen's sign), the production of pain and paresthesias within 30 seconds of holding the wrist in complete flexion. (4) Weakness in thumb opposition and abduction with atrophy of the thenar eminence present in approximately 50% of the cases.

Electrodiagnostic studies are not necessary to make the diagnosis in the majority of patients with carpal tunnel syndrome. Clinical evaluation of the patient's symptoms and signs is usually sufficient to arrive at an accurate diagnosis. However, in patients with subjective findings only and patients with referred pain from the wrist, the elbow, or shoulder, the measurements of motor and sensory conduction will be of diagnostic help. The normal sensory latency for the median nerve at the wrist is 3.0 msec. and the normal motor conduction is 5.0 msec. In early cases of carpal tunnel syndrome, sensory latency may be prolonged before motor latency is affected. These nerve conduction studies are of most benefit in patients with cervical arthritis or with injuries to the cervical spine. These patients often have pain and numbness in the thumb and index finger and the exact site of nerve involvement causing these symptoms can be determined only by careful electrodiagnostic studies. However, one must remember that carpal tunnel syndrome may be present with no evidence of EMG abnormalities, and treatment should be instituted when and if the diagnosis is made on clinical grounds.

Etiology of carpal tunnel syndrome has not yet been fully determined. Thickening or fibrosis of the flexor synovium within the carpal tunnel is the most common cause of the syndrome noted in larger series.[3] Tenosynovitis may be of rheumatic or other collagen disease origin. The improvement noted after injection of a steroid perparation denotes the inflammatory nature of this etiology. Other manifestations of chronic tenosynovitis, notably trigger fingers, DeQuervain's disease, tennis elbows and tendonitis of the shoulder, often accompany the carpal tunnel syndrome.

Hormonal changes may play a causative role in patients with carpal tunnel syndrome. Most cases by far are in women at or near the menopause. Diabetes mellitus and myxedema have also been associated with carpal tunnel syndrome. Hypothyroidism was present in 6.3% of the cases in a recent Mayo Clinic series,[4] and in 10% of the cases analyzed by the University of Vermont in 1973.

Medical treatment suffices in approximately one-half of the cases of carpal tunnel syndrome, the other 50% requiring surgery. Physicians dealing with a specialized referral practice will find that by the time referral occurs,

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conservative measures will already have been instituted, and a greater percentage of these patients will require surgical treatment. Early enthusiasm regarding injections of steroid preparations in the carpal tunnel have not proved to give lasting relief in most cases. Injections should be made with a 25-gauge needle inserted in the ulnar side of the median nerve in the carpal tunnel. A useful landmark is the Palmaris longus tendon when present. Care should be taken not to produce paresthesias when injecting, and if no release is obtained from a single injection, it is unlikely that relief will be obtained from repeat injections.

Anti-inflammatory medications, such as phenylbutazone, in a short course of treatment may also be helpful. Diuretics have been tried to reduce edema in the carpal tunnel and have had some effect in mild cases. Night splinting to avoid wrist flexion is of benefit in those cases prone to this disposition during their sleep habits. However, long-term splinting has not been effective. Overall, if symptoms and signs of carpal tunnel syndrome are persistent or progressive after or during a 10- to 12-week period, surgical intervention is indicated. Thenar atrophy, if present, is an absolute indication for surgical intervention.

Prior to describing surgical treatment, the anatomy of the carpal tunnel should be reviewed. The floor and side walls of the carpal tunnel are formed by the carpal bones.

The roof of the tunnel is formed by the fibrous transverse or volar carpal ligament. The carpal tunnel is a palmar structure, not a wrist structure. The floor is formed by the lunate, capitate, and lesser multangular, the radial wall by the greater multangular and navicular, the ulnar side wall by the hamate and pisiform. The volar ligament stretches from the prominence of the hamate and pisiform ulnarly to the navicular and greater multangular radially. The contents of the tunnel are the median nerve and the flexor tendons to the fingers, both superficial and deep, with their associated tendon sheaths.

The operative treatment of carpal tunnel syndrome is relatively simple. General anesthesia is not necessary. Regional block anesthesia, utilizing a double tourniquet and 40 cc of ½% lidocaine is the method of choice. This assures an adequate level of anesthesia and a bloodless field.

The proper incision is important. Traditionally, a transverse incision at the wrist has been employed, but this method is not recommended for the following reasons: (1) the carpal tunnel is located in the base of the palm and not at the wrist, and thus this incision does not give adequate exposure of the transverse carpal ligament. (2) Space-occupying lesions cannot be identified through this incision. (3) Damage to the recurrent sensory branch of the median nerve can occur. (4) Blind sectioning of the carpal ligament through this incision can cause injury to the superficial vascular arcade distal to the carpal tunnel. (5) The motor branch of the median nerve cannot be visualized through this incision.

The type of incision best suited for this procedure is a curved longitudinal incision made parallel to the thenar crease in line with the radial axis of the ring finger. This incision spares the sensory branch of the median nerve and gives excellent exposure and enables the carpal tunnel to be fully explored. If a more extensive procedure, such as synovectomy or neurolysis, is needed, the incision can easily be extended across the wrist. Using this incision, the entire operative procedure should take no more than 20 to 30 minutes in experienced hands, and excellent functional and cosmetic results should ensue.

An Evaluation

A total of 27 cases in 20 patients with carpal tunnel syndrome operated on from July, 1973, to January, 1975, by the orthopedic service, Montgomery County Hospital, Blacksburg, Virginia, were evaluated. Followup was from 9 months to 2½ years. Seventeen of the patients were female; three were male. The oldest individual in this series was 80, the youngest, 20, with an average age of 56. Trauma

was the etiologic agent in two cases, one being a progressive median nerve palsy resulting after transcaphoid perilunate fracture dislocation of the wrist, requiring a carpal tunnel release 3 weeks post injury. Rheumatoid arthritis was associated with five cases, diabetes mellitus in three.

Thyroid studies were performed to determine associated hypothyroidism. Free thyroxine and T3 levels were measured, and while nine individuals had low normal values, all patients were euthyroid.

There were no postoperative complications. Following surgery all individuals in this series except one were able to resume full preimpingement activities. Five patients complained of occasional discomfort in the wrist area after heavy use of their hands, but, significantly, none of these patients operated on had return of night pain or paresthesias.

There were two recurrences at three to six months postoperative, with one individual requiring repeat surgical release and neurolysis with a satisfactory final result. This secondary procedure was required because of initial inability to recognize the extent of nerve sheath involvement necessitating more extensive release. The second case is interesting in that this individual initially was operated on with less than the classical characteristics after nerve conduction studies revealed significant entrapment of the median nerve in the carpal tunnel. This patient did well postoperatively, but then developed recurrence of symptoms on resumption of work activity requiring repetitive wrist flexion exercise. At nine months postoperative, repeat nerve conducton studies were interpreted as normal. She was treated conservatively again and responded well to a single steroid injection. This individual has not been allowed to resume heavy work activity requiring forced wrist flexion and is the only individual in this series not returned to full preimpingement activity.

Conclusions

The presence of night pain and paresthesias at the wrist associated with decreased sensation in the median nerve and positive Tinel's and Phalen's tests are diagnostic of the carpal tunnel syndrome. Surgical treatment is not necessary in every case, but when symptoms are not relieved or progressive, or if thenar muscle atrophy is present, appropriate surgical intervention is indicated and should not be delayed. Results of surgical treatment are excellent and complications should be minimal. The traditional transverse wrist incision should be avoided and the recommended surgical technique has been described.

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Case Reports . . . .

Posttraumatic Splenic Cyst

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Cysts of the spleen are rare, and for this reason, the reporting of a single case seems justified. This report concerns a posttraumatic splenic cyst which was the cause of left upper quadrant discomfort in an otherwise normal, healthy young female. A description and brief comment are offered to emphasize the clinical features of this uncommon lesion.

Case Report

An 18-year-old white female was admitted to the University of Virginia Medical Center on June 10, 1974, because of generalized dull abdominal pain of six years' duration, which was not associated with food ingestion, nausea, vomiting or change in bowel habit. Ten years previously, the patient had been kicked in the left side of the upper abdomen by a playmate. At that time she was admitted to another institution and observed for several days because of slowly resolving left upper quadrant tenderness.

On examination, there was no abdominal tenderness or mass, and pelvic and rectal examinations were normal. Laboratory data at the time of admission revealed an hematocrit of 42% and white blood cell count of 9,000, with a normal urinalysis and liver enzyme profile. Roentgenograms of the chest and abdomen and an intravenous pyelogram were normal. Upper gastrointestinal series revealed a large indentation in the fundus of the stomach (Fig. 1), with downward and medial displacement of that organ. Barium enema showed caudad displacement of the splenic flexure of the colon by a large left upper quadrant mass. A technetium (99mTc) scan of the spleen disclosed a large defect in the superior pole of that organ. Sonography revealed the defect to be cystic. In this case, angiography, often a very important method in the delineation of intraabdominal masses, was not necessary for preoperative diagnosis.

Splenectomy was performed, and a large cyst was found in the superior pole of the spleen (Fig. 2). The combined weight of normal splenic



Fig. 1. The upper gastrointestinal series showing extrinsic compression of the gastric fundus.



Fig. 2. The surgical specimen showing a large cyst in the superior pole of the spleen.



Fig. 3. Cut section of the cyst showing coarse trabeculation.

tissue and cyst was 681 grams. This yielded approximately 400 cc of straw-colored fluid when sectioned. The wall was markedly trabeculated, and on histological examination was found to be acellular. The patient's recovery was complete and uneventful. She remains well two months postoperatively.

Discussion

In 1829, Andral[1] recorded the first case of a splenic cyst, found at autopsy. Pean,[2] a French surgeon, performed the first successful splenectomy for a cyst in 1867. Fowler,[3] in 1940, analyzed 265 collected cases and offered a classification of nonparasitic splenic cysts. According to this scheme, primary cysts, which account for 25% of reported cases, are those with a cellular wall lining. The most common type of primary splenic cyst is the hemangioma, but congenital serous cysts, transitional cell, epidermoid and dermoid cysts and lymphangiomas have also been described. Presumably, these cysts are the result of neoplasia or developmental anomalies whereby aberrant cells become trapped during development of the splenic anlage. Other classifications, all modifications of that proposed by Fowler, have been suggested. The most recent and least complex is that of Martin[4] who has classified nonparasitic primary cysts as either congenital or neoplastic.

Eighty percent of secondary cysts are caused by trauma.[3] Presumably a subcapsular hematoma forms following injury, and, with reabsorption of the hematoma, a cystic mass is formed which is lined by fibrous tissue. Less commonly, cysts form after parenchymal hemorrhage in malaria, leukemia or infectious mononucleosis, or following splenic infection during typhoid fever or tuberculosis.

Cysts may be solitary or multiple, unilocular or multilocular. The interior of the cyst wall is usually smooth, but may show marked trabeculation. Calcification is occasionally present. The size is variable; the largest recorded cyst contained 10 liters of blood.[3] The character of the content of posttraumatic secondary cysts vary with their age. Early on, it may contain coagulated blood; later, after resorption of the hematoma, straw-colored fluid may be present.

Splenic cysts may be asymptomatic, discovered only on routine physical examination or at autopsy.

Qureshi and Hafner[5] analyzed 75 consecutive cases of splenic cyst reported in the English language, and found the most common symptom was discomfort in the left hypochondrium, epigastrium, or lower left chest. Postprandial exaggeration of the pain is common when the stomach is compressed. Dyspnea, repeated respiratory infections, tachycardia, pyelonephritis, hiccough, nausea, vomiting, constipation and urinary frequency may be caused by pressure from the cyst on the adjacent viscera. Rarely, a catastrophic illness is caused by spontaneous or traumatic rupture of the cyst. Nearly half the patients have a palpable mass in the spleen. Such masses are usually non-tender and may have fluid waves on percussion. Flaring of the left lower rib cage with widening of the intercostal spaces may occur with extremely large lesions.

Splenic cysts must be differentiated from a variety of other left upper quadrant masses. If the cyst is calcified, the roentgenographic diagnosis is made easily; unfortunately, this occurs only in about 10%[6] of patients. The plain chest roentgenogram may show elevation of the left hemidiaphragm, atelectasis of the left lower lobe of the lung, pneumonia or shift of the heart to the right. Contrast studies of the gastrointestinal tract may show medial or downward displacement of the stomach and colon.

Splenic scans using colloidal gold, chromium tagged red cells or technetium are quite helpful in identifying large splenic areas that fail to concentrate any radioactivity. Splenic angiography, probably the most useful preoperative diagnostic aid, demonstrates stretching of the splenic artery branches around an enlarged avascular area.[7] The surrounding normal parenchyma is smoothly compressed.

The definitive treatment of splenic cyst is splenectomy which can be performed with minimal mortality and morbidity.

Summary: A large splenic cyst was the cause of the left quadrant discomfort in an 18-year-old female with a history of blunt abdominal trauma 10 years previously. The disorder was suspected preoperatively because of data obtained from upper gastrointestinal series, splenic scan and sonography. Splenectomy was followed by an uncomplicated recovery and relief of symptoms.

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Familial Surgical Intracranial Infections

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Reports of suppuration within the cranial cavity have appeared in the medical literature for centuries. Infections (epidural empyemas, subdural empyemas, brain abcesses, etc.) are still encountered every day in neurosurgical practice in spite of great advances in antibiotic therapy.

This is a report of two surgical intracranial infections occurring in the same family within a 3-week period.

Case 1

R. M., a 66-year-old black male, had been in good health until 8-9-72 when he was struck in the head by an air conditioner he was installing. He was not rendered unconscious. Two superficial lacerations, one above and one below the left orbit, were sutured by his local physician. On 8-11-72 he complained of a headache. Skull x-rays were normal and he was started on penicillin for a questionable infection of the lacerations. The sutures were removed on 8-18-72. The headache persisted, and on 8-21-72 he experienced difficulty talking and was referred to the Neurosurgical Service at the Medical College of Virginia. Initial examination revealed BP 180/90, P 80, T 99.1°F. Routine lab studies were all within normal limits. The patient was globally aphasic but otherwise the examination was normal. Angiograms revealed a small left extra-axial mass. A twist drill aspiration of 10 cc of chronic subdural hematoma was performed. The culture of the aspirated fluid revealed salmonella, Group E. He was started on chloromycetin and taken to surgery where routine burr holes were made and drainage of the subdural space accomplished using red rubber catheters. Blood and stool cultures were negative. He was continued on chloromycetin for six weeks. The aphasia gradually resolved and followup examination two years later was entirely normal.

Case 2

R.M., a 16-year-old black male, was the son of the patient in Case 1. The young man was entirely normal until 48 hours prior to admission when he developed lethargy, fatigue and frontal

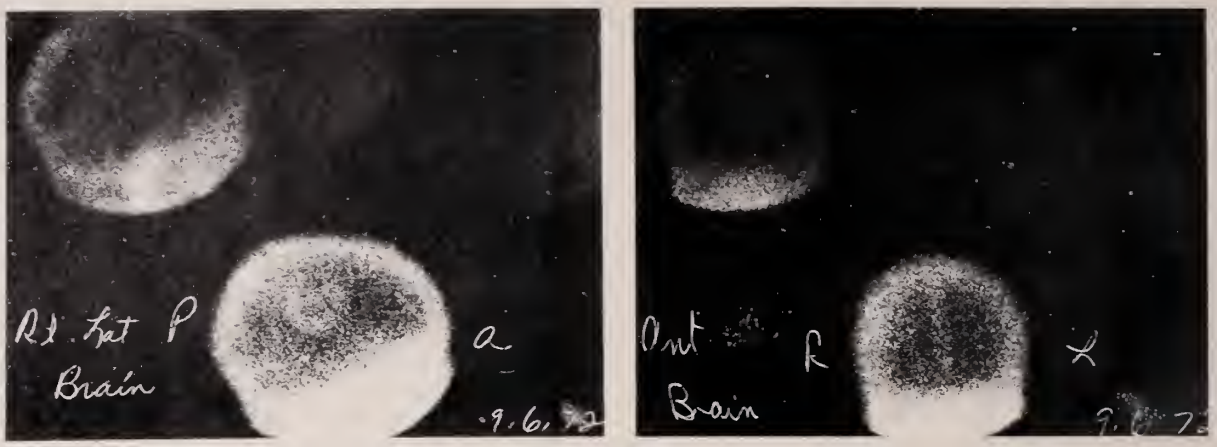


Fig. 1. Brain scan obtained on 9-6-72. Left, lateral view reveals doughnut shaped lesion in the right posterior parietal area. Right, the anterior view is normal.

headache. Twenty-four hours prior to admission he noticed decreased strength in his left upper extremity and drooping on the left side of his face. He was referred to the Neurosurgical Service at the Medical College of Virginia on 9-2-72. Initial examination revealed BP 134/80, P 84, T 100°F. The patient was lethargic but easily arousable and fully oriented. Fundiscopic examination revealed early papilledema. There was decreased pin prick on the left side of the face and a left central facial paralysis. Motor examination revealed a left hemiparesis with the arm more affected than the leg. The general examination was normal. The initial lab results were normal (hgb 14.4, WBC 7,000) except for a sed rate of 50.

A right carotid arteriogram was performed on the day of admission which revealed a 1 cm right left shift of the intracerebral vein and a 1 cm distal shift of the arterior cerebral artery. The sylvian point was also displaced and there appeared to be an avascular mass in the right parietal region. A twist drill hole was performed in the area of the avascular mass, and an 18-gauge brain needle passed, but no suppuration was encountered. Since the patient's father was in the hospital with a salmonella subdural empyema the patient was started on penicillin and chloromycitin intravenously.

A brain scan (Fig. 1) performed on 9-6-72 revealed a doughnut shaped lesion in the right parietal area. A repeat carotid arteriogram on 9-7-72 revealed the mass to be enlarging. On 9-8-72 a repeat twist drill hole was performed with aspiration of 30 cc of purulent material from the right parietal region. Culture of this yielded anaerobic streptococcus and herillea vaginecola. There was dramatic improvement in the patient's clinical condition and a disappearance of the left hemiparesis. Numerous blood cultures were obtained and were all negative. On 9-29-72 a craniotomy was performed with complete removal of the brain abscess capsule. Antibiotics were continued for six weeks.

Two years later the examination was entirely normal except for a slightly abnormal electroencephalogram in the right parietal area.

Discussion

Numerous reports in the literature deal with infected subdural hematomas. Most salmonella empyemas occur either in young patients or in patients who have had gastric surgery. [1-4] Our patient had not had previous surgery and epidemiology followup by the Health Department revealed no source for the salmonella infection. The point of routine aerobic and anaerobic culture of subdural fluid collections at the time of removal is well demonstrated by this patient.

Our Case 2 proved to have an anaerobic streptococcal brain abscess, but had been on antibiotics for six days prior to obtaining the specimen. It was unusual only because of the concurrent hospitalization of his father with a salmonella infected subdural hematoma. Again the authors stress the importance of obtaining aerobic and anaerobic cultures at the time of removal of intracranial suppuration.

This is the first report to our knowledge of noncommunicable familial intracranial surgical infections. Both cases well illustrate the point of routinely culturing abnormal collections within the cranial vault.

(References on page 165.)

From the Division of Neurological Surgery, Medical College of Virginia, Richmond.

Extrahepatic Lesions Causing False-Positive Liver Scans

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Hampton, Virginia

Photoscanning of the liver[1-3] is a valuable diagnostic procedure for intrahepatic lesions. Thus ^{99m}Tc-sulfur solloid liver scan in patients with primary or secondary neoplasm of the liver, liver abscess, cyst or cirrhosis of the liver may show either focal defect or heterogeneous distribution of the colloid. We are presenting here three cases of retroperitoneal (renal or extrarenal) mass causing such changes in the liver scintiscan, although the liver itself was quite normal in each case.

Case 1

A 30-year-old man was admitted because of gross painless hematuria two days prior to admission and severe right flank pain for 24 hours prior to admission. He denied history of tuberculosis. Physical examination revealed well developed, well nourished white male in moderate distress with normal vital signs. Heart and lungs were clinically normal. Abdominal examination was done with difficulties due to excessive muscle guard. There was slight tenderness in the right flank. No definite mass or organs were palpable. A flat plate of the abdomen showed nonvisualization of the right renal shadow. A retrograde pyelogram revealed displacement (upward and medial) and distortion of the right collecting system. Cystoscopy revealed generalized cystitis with a blood clot over the right ureteral orifice. An arteriogram showed upward displacement and marked stretching of the right renal artery with some neovascularization of the right renal area. A liver scintiscan (Fig. 1) with ^{99m}Tc-sulful colloid showed focal defect in the right lobe of the liver best seen in the anterior, posterior and right lateral views. An exploration revealed a huge intrarenal mass on the right. Right nephrectomy and partial adrenalectomy were performed. Post operative liver scan (Fig. 2) with the same radiopharmaceutical was normal.

Summary: Direct visualization verified the presence of right intrarenal mass and normal liver. However, preoperative liver scan was abnormal.

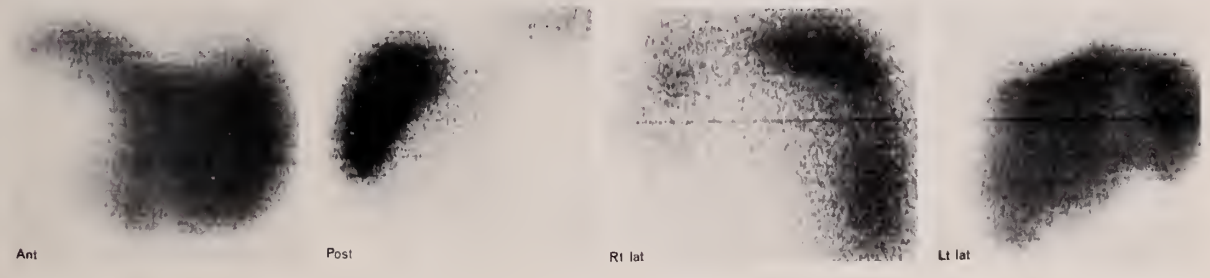


Fig. 1. Preoperative liver scan (4 views) with ^{99m}Tc-sulfur colloid shows focal defect in the right lobe of the liver best seen in the anterior, posterior, and right lateral views. Exploration confirmed the absence of mass in the liver.



Fig. 2. Postoperative liver scan (4 views) with same radio-pharmaceutical. Kidney mass was excised. Liver scan returned to normal.

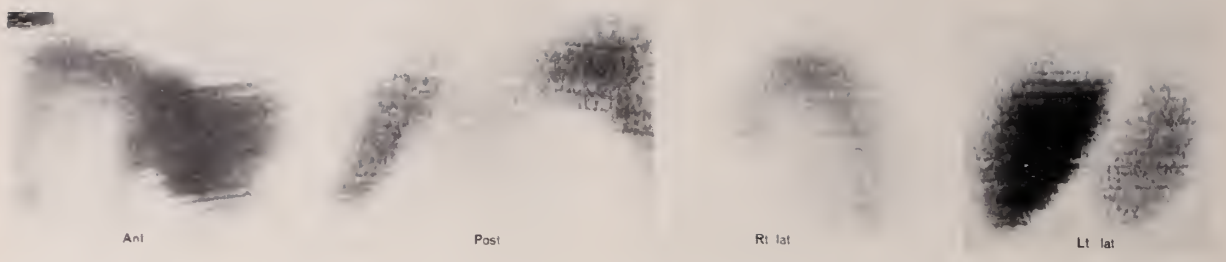


Fig. 3. Liver scan (4 views) with ^{99m}Tc-sulfur colloid demonstrates an area of absent activity in the right lobe of the liver (anterior view), pushing the liver anteriorly (right lateral view) and superiorly (posterior view).

Case 2

A 64-year-old male was admitted for pain across his back at the level of the iliac crests and radiating from the right hip down to the knee. A vague pain had been present since 18 months prior to this hospitalization. The pain became more intensified four months prior to admission and even much worse three months later, incapacitating him to work. At this time he was hospitalized locally for a period of 2½ weeks. Upper GI series at that time was normal. A barium enema showed diverticuli of the colon. A bone survey revealed old spine injury. His appetite has been poor since that time and he lost 10 pounds weight during this time. He had had TUR a year ago; the tissue was benign. Physical examination revealed thin, chronically ill man with a BP 140/80, pulse 84 per minute and regular. The heart and lungs were clinically normal. The abdomen was soft and nontender. There was fullness in the right upper quadrant. No costovertebral tenderness was detected. A scout film showed flaky calcification in the right upper quadrant, faint renal outline on the right and indistinct cortical margins on the right side of L_1 and L_2 with wedging of L_2. A pyelogram revealed normal collecting system on the left. On the right side, only the lower calcyceal system was visualized. There was outward displacement of the right kidney. An arteriogram revealed displacement of the aorta to the left with an extrinsic pressure on its wall just below the origin of the right renal artery. The right hepatic artery and its branches were stretched. A liver scintiscan (Fig. 3) disclosed a focal defect in the right lobe of the liver pushing the liver anteriorly (right lateral scan) and upward (posterior scan). The patient underwent surgery, and the right renal mass was excised. A postoperative liver scan turned out to be normal.

Summary: In this patient, pyelogram suggested mass in the upper pole of the right kidney, most likely a hypernephroma, which was proved by surgery and histological section. The liver scan revealed a defect in the right lobe.

Case 3

A 2-year-old girl was noticed to have increasing fatigue, irritability, size of her abdomen and pain in the right upper quadrant for seven weeks prior to this admission. Three weeks later, she was admitted to a local hospital because of further enlargement of her abdomen. Upper GI series and barium enema at that time revealed a lesion in the right upper quadrant pushing the small bowel and colon downwards and to the

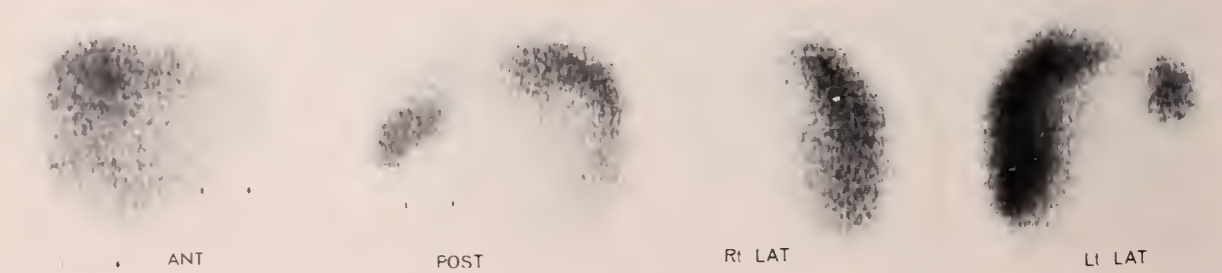


Fig. 4. Liver scintiscan (4 regular views) with ^{99m}Tc-sulfur colloid does not demonstrate definite focal defect. The renal impression on the posterior view is more than normal.

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* Warning
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

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Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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Effectiveness across the spectrum of most common forms of insomnia

Awake too long, awake too often, awake too early...

These are the most common forms of insomnia, and may occur singly or in any combination. The night of troubled sleep depicted here comprises all three types. As the night progresses from left to right, each sleep stage is identifiable by its own shade of gray. Blue represents "Awake."

As you can see, this hypothetical "patient" takes well over an hour to fall asleep, awakens several times during the middle of the night and awakens too early in the morning.

Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



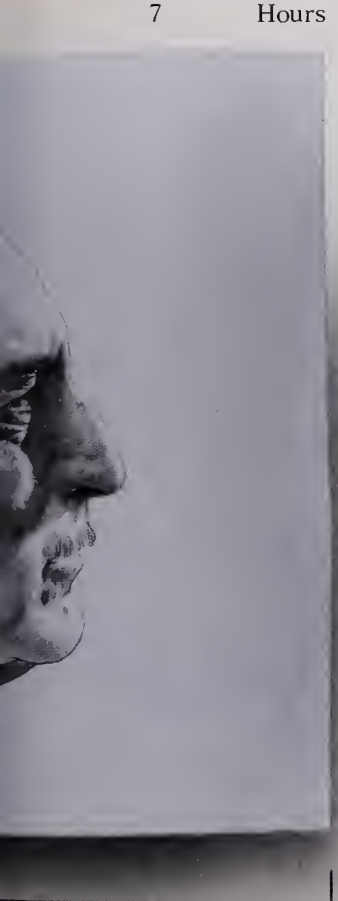
The insomnias most often occurring in young and older adults

For patients with trouble falling asleep (common in young adult insomnia patients), Dalmane (flurazepam HCl) 30 mg provides sleep within 17 minutes, on average. For those with trouble staying asleep or sleeping long enough (common in those over 50), Dalmane offers increased total sleep time with fewer nocturnal awakenings. These clinical results were demonstrated in studies conducted in four geographically separated sleep research laboratories.[1-4]

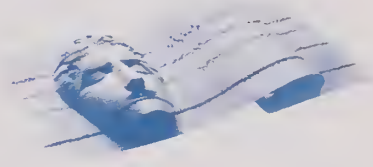
The relative safety of Dalmane (flurazepam HCl) is well documented

Dalmane (flurazepam HCl) is relatively safe and well tolerated; morning "hang-over" has been infrequent. The usual adult dosage is 30 mg; in elderly or debilitated patients, limit initial dosage to 15 mg to preclude over-sedation, dizziness or ataxia. Caution patients about possible combined effects with alcohol and other CNS depressants.

Broad-spectrum medication for the most common forms of insomnia



Awake too early



Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

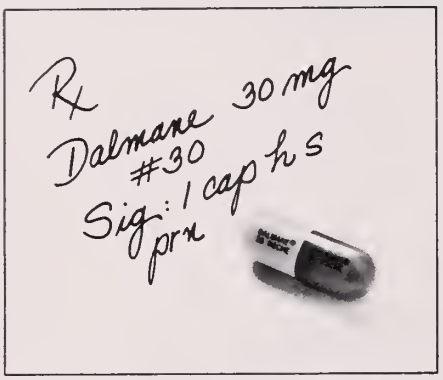
- ☐ induces sleep rapidly
- ☐ reduces nighttime awakenings
- ☐ lengthens total sleep time

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Please see following page for a summary of complete product information.

Broad-spectrum medication for the most common forms of insomnia

Dalmane®
(flurazepam HCl) ℞ IV



Objectively proved in the sleep research laboratory, Dalmane

- induces sleep within 17 minutes, on average
- reduces nighttime awakenings
- provides 7 to 8 hours sleep, on average, without repeating dosage

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum benefic effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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left. She was at that stage transferred to this hospital. She had 6 pounds weight loss during this 7-weeks period. A pyelogram revealed lateral displacement of the right kidney with extrinsic pressure effect on the pelvis and normal calyces. Left kidney was normal. This was consistent with retroperitoneal extrarenal mass, more likely a neuroblastoma. A liver scan (Fig. 4) with ^{99m}Tc-sulfur colloid did not reveal definite defect in the regular views, although the renal impression on the posterior view was more than normal, which prompted us to get oblique views. Figure 5 represents the two oblique views, which disclosed a defect between the left lobe and the spleen. A renal scan (not shown) with ^{203}Hg-chlormerodrin showed lateral displacement of the right kidney and some defect in its upper pole. An exploratory laparotomy revealed a large mass originating in the retroperitoneum.



Fig. 5. Liver scan (oblique views) with same radiopharmaceutical. Note extrinsic pressure effect on both left and right lobes of the liver.

Right adrenalectomy and nephrectomy were performed. However, the patient died of cardiac arrest. Postmortem and histological examination confirmed the diagnosis of neuroblastoma.

Summary: Localized discrete area of absent radioactivity, suggestive of intrahepatic mass, was present in the liver scan. Exploration revealed large retroperitoneal mass on the right with some extension to the left.

Discussion

A defect or cold area in the liver scintiscan is usually attributed to an intrahepatic space-occupying lesion which does not pick up the colloid. In this paper, cold areas due to extrahepatic tumors which indent, displace and distort the liver scan pattern are described. The growth expansion of the extrahepatic tumors displaces a portion of the liver, thus producing a defect on the scan. Three cases of retroperitoneal mass are therefore presented as an illustration of how the extrahepatic mass may cause defect in liver scan. In all cases, photoscan detection of extrahepatic mass displacing the right lobe was suspected independent of other studies. At surgery, a huge tumor of the right kidney (in two cases) or a retroperitoneal neuroblastoma (third case) was found to occupy most of the right upper quadrant of the abdomen. The postoperative liver scans failed to show any defect and the liver returned to its original position. In preoperative scans, the liver was pushed to the left and anteriorly. For this reason, unlike normal conditions, the right lobe of the liver was seen in the left lateral scan. In Case 3, regular anterior and posterior views did not demonstrate the defect well, but the oblique views showed up the defect. The posterior view in oblique position demonstrated upward displacement of the right lobe of the liver and the right lateral view revealed anterior displacement of the liver. Since this patient died on the operation table of cardiac arrest, no postoperative scan was obtained.

The practical contribution of this report is recognition of the fact that not all defects in the liver are due to intrinsic lesions. Extrahepatic lesions may cause false positive liver scan in an otherwise normal liver. One has also to differentiate between compression and actual involvement of the liver. Physicians should be cautious in interpreting a hepatic lesion in patients with questionable kidney disease or other retroperitoneal mass, especially when the defect is most prominent on the posterior scan. Extra studies like pyelogram or arteriogram should be taken in differentiating the extrahepatic lesion from an intrahepatic one. Early involvement of adjacent liver tissue due to its direct invasion by a retroperitoneal mass cannot be definitely ruled out by liver scan alone.

(*References on page 165.*)

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Cancer Trends....

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Charlottesville, Virginia

Team Approach to Management of Childhood Malignancies

THE REVEREND RICHARD P. CHASSE

WITH THE DEVELOPMENT of effective anticancer drugs and intensification of treatment programs, the prognosis in acute lymphocytic leukemia and other childhood malignancies has considerably improved over the last two decades, and 50% of leukemic children are now expected to live five years or more in remission. As in the past, the patient-family-physician relationship must encompass the complexities of social, emotional, and religious needs which arise during the course of the disease. It has become increasingly evident that a team approach to management of these problems serves to provide optimal care to the patient and family.

At the Medical College of Virginia, physicians, nurses, patient counselors, social workers, and a play therapist have pooled their resources to provide both patient and family of a child with cancer with total health care.

Once the diagnosis of childhood cancer is made, a series of challenges must be met by the patient, family, and medical staff. These challenges occur principally during three major periods: at diagnosis, during adjustment to the disease, and at the time of death.

Diagnosis

When a child is referred to the pediatric hematology-oncology service at the Medical College of Virginia, the parents may suspect that something is seriously wrong. The evaluation period which follows may be particularly disturbing as various diagnostic studies are performed. It is a time of confusion, anxiety, fear, anticipation, and, above all, a time in which parents, contrary to all they have been told, try to convince themselves that there is nothing seriously wrong with their child. These thoughts may terrify them. It is usually in this frame of mind that the parents must meet with the physician to discuss the diagnosis, once it has been established.

At MCV our management approach takes into account the emotional needs of the parents and child, which must include sensitive, responsive support on the part of the staff. In order to provide this kind of support from the time of diagnosis, it has been our practice to hold the first conference in the presence of a counselor-chaplain. The diagnosis is explained, and the treatment plan and prognosis are discussed in lay terms. Questions are encouraged, and they are answered with openness and honesty. Parents are encouraged to express the grief, anger, or hostility which follow the announcement of what to them is a death sentence.

During this conference and throughout the period of initial hospitalization, parents are also made aware of the comprehensive services available to them. The team is especially attuned to the immediate rehabilitation of the child and the family, the goal being return to as near normal daily activities as possible. Just

The Reverend Chasse is patient counselor and chaplain, MCV/VCU Cancer Center, Richmond.

Sponsored by the Professional Education Committee, Virginia Division, American Cancer Society.

as discussion of the diagnosis is required to initiate treatment, so too is the establishment of a good working relationship between the team and the family necessary for optimum management of the social and emotional aspects of the disease. Failure to establish this relationship has led to major difficulties in the adjustment of the family after remission has been achieved.

Adjustment

The day before discharge, parents are familiarized with the routine of their return visits to the outpatient clinic. It is also necessary at this time to discuss the adjustments the family will have to make upon returning home and to inform them about coping with any problems which may arise.

Most parents feel overwhelmed by the additional responsibility which has been thrust upon them, i.e., caring for a child with a potentially fatal disease. The team assures them of its continued involvement and introduces them to the parents group established to provide emotional and spiritual support as well as to provide up-to-date information on the care and treatment of childhood cancer. The group is conducted by the patient-counselor, with the physicians and other team members present.

Experienced parents will often suggest to newcomers ways in which they have successfully adjusted to the illness in their family. Questions raised may range from "Why my child?" to "What can we expect when treatment and drugs fail?". The ultimate purpose of this group is honest, open communication between parents, and between team members and parents. Group therapy has provided many families with mechanisms to deal with the uncertainties of malignant disease. Often the disease has been described as a "dark cloud hanging over our heads waiting to unleash its fury in the storm of relapse". Yet, due to the nature of treatment, parents have also stated, "My child has been in remission so long now, I sometimes feel I have to convince myself that he does have leukemia". The illusion of perfect health is ever present, and attendance in the group reminds the parents of the reality of their situation. "Once a month, like my child, I get a dose of reality in the group".

Death and Grieving

In spite of treatment, parents are well aware of the possibility of disease recurrence and death. The team assists parents in providing good care in the hospital or at home. During this final period in the illness parents begin to grieve as the loss of their child approaches. Team members serve as a welcome ear for these grief reactions and encourage expression of grief. We have learned that grief brings a peaceful acceptance of the child's death. This acceptance is often experienced at the bedside as a result of the honesty which parents have maintained with the child, themselves, the physician, and the team members.

Summary

The treatments for childhood cancer have improved greatly over the past 30 years. Recently, we have had the opportunity to widen our view in the total treatment of the family. No longer are we merely concerned with the immediate preoccupation of prolonging life, but we work also to provide a better quality of life for patient and family. Where there was once hopelessness, now there is help and hope. Reality is given to this hope in the fact that with cancer there remains a life which may still be called good. Remissions occur more frequently and prevail longer—so much so, indeed, that we as a team now begin to face, with many of our disease-free teenagers, the problems of college, jobs, and the question we all seek to answer, "What can I do with my life?".

COMMENT

Chaplain Chasse's paper serves to remind us as primary physicians or oncologists that we do not work in a vacuum. Patients and their parents have always known this. When hospitalized, they know that their physician will be busy in the outpatient office, committee

meetings, etc., and will be available for only a limited amount of time each day to check on their progress and talk. On the other hand, nurses, chaplains, attendants, and other personnel, who spend long working hours on patient units, are more readily available at times of the patient's choice to talk about his concerns. It is also important to remember that a patient or his family may be reluctant to voice concerns and complaints to the physician, who is virtually responsible for his life or death.

Those of us who strongly advocate the regionalization of care of children with cancer need to be reminded of the pivotal role of another member of the team—the family physician. Too often it is erroneously assumed that when a patient is referred for treatment, the primary physician wishes no longer to participate in the supportive management of the child. He is, however, frequently the best equipped and most willing to understand how a family will react under stress, to be familiar with the home environment, and to be available for followup after the child's death as he sees other members of the family. In our enthusiasm to avail our patients of the talents of many health professionals, we should not lose sight of that most prized patient service—continuity of support by one individual. When the referring physician wishes to serve in this pivotal position, those of us contributing to the patient's care at specialized centers should not usurp his role as leader of the supportive team.

Diane M. Komp, M.D.
Associate Professor,
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South Richmond's Only Community Hospital

Abstracts....

The papers here abstracted are to be presented before the Virginia Regional Meeting of the American College of Physicians at Charlottesville on February 14. Dr. Edward W. Hook, Jr., Charlottesville, is Governor for Virginia of the College, and Dr. Douglass O. Hill, Winchester, is President of the Virginia Society of Internal Medicine. Chairmen for the meeting are Dr. Merle Sande and Dr. John S. Davis IV, Charlottesville.

Acute Silicosis in Sandblasters—*Paul M. Suratt, M.D.*, and *Washington C. Winn, Jr., M.D., Charlottesville.*

Four cases of acute silicosis occurring in the same Virginia sandblasting plant are presented. The patients were exposed to 18 times the maximum accepted limit of respirable silica for a mean period of 3 years. Three of the 4 patients died within 5 years of their initial exposure. Two cases were originally diagnosed as sarcoidosis, one for a year; the other was refused workman's compensation for 20 months because his exposure to silica was felt to be too brief. Pathological material was available in 3 cases, all of whom had swirling silicotic nodules with few doubly refractile rods, and alveolar proteinosis. Two had non-caseating granulomas which appeared to be part of the silicotic process. There was no evidence of silico-tuberculosis. In two cases in whom serological studies were available, LE cells, antinuclear factor and anti DNA were present.

Acute silicosis continues to be an occupational hazard of sandblasting since filter masks fail to prevent inhalation of respirable silica. Alveolar proteinosis and non-caseating granulomas appear to be more commonly associated with acute silicosis than has been previously recognized.

Chronic Home Peritoneal Dialysis: An Alternative—*Jorge Roman, M.D., Veterans Administration Hospital, Salem.*

Home peritoneal dialysis (HPD) has been considered by some to be an acceptable alternative for patients not trainable for home hemodialysis (HHD). In May 1974 we began a chronic home peritoneal dialysis program for such patients.

Eight patients, aged 33-66 years (Av:51) were dialyzed for 30-53 h/week for an average of 7.9 months. Tenckhoff catheters and commercial solutions were used. Average training time was only 3 weeks compared to 6-9 months for HHD.

Patient acceptance was good, 6/8 preferring HPD to HHD. However, a helper was used in 7/8 patients and home placement failed in 2 others for lack of helpers. Complications included peritonitis (4 episodes in 3 patients) and protein depletion (3/8), controlled by increasing dietary protein. Because of poor dialysance, hemodialysis had to be instituted in one patient.

There has been only one fatality since the inception of this program. Incidence of readmissions for acute illness compared favorably with patients on HHD.

Home peritoneal dialysis is useful in selected patients with end stage renal failure and results compare favorably with other therapeutic modalities.

Electrocardiogram in the Athlete—*P. T. Rodilosso, M.D.*, and *J. E. Shuman, M.D., Arlington.*

Eighteen months ago, we examined 80 players in a training camp for the World Football League. The electrocardiograms were reviewed in detail. Sinus bradycardia was a common finding and will not be discussed in the paper. There were six other abnormalities found in the tracings: one Wenckebach phenomenon, one sinus bradycardia with an escape ventricular nodal rhythm, and three with abnormal T waves. Examples of these arrhythmias will be shown, and the effect of exercise, atrapine, and carotid sinus massage will be demonstrated.

It was concluded that the abnormalities were due to increased vagal tone present in these athletes, and that they are reversible by increasing the cardiac rate. Recent literature will be discussed.

Fiberoptic Transbronchial Lung Biopsy in the Diagnosis of Localized and Diffuse Parenchymal Lung Disease—*Richardson Grinman, M.D., Eldridge H. Derring, Jr., M.D., George W. Burke, M.D., James P. Baker, M.D., Medical College of Virginia, Richmond.*

With the aid of fluoroscopic guidance, the results of 25 consecutive cases of transbronchial lung biopsy are reviewed to determine diagnostic yield. A clinical, cytologic, pathologic, and/or bacteriologic diagnosis was made or confirmed in 22 of the 25 cases (88%). In two cases the diagnosis was missed, and there was one false positive diagnosis. Complications included minor blood streaking of the sputum and one 15% pneumothorax. The available literature on fiberoptic transbronchial lung biopsy is briefly reviewed. It is concluded that transbronchial lung biopsy with fluoroscopy has a high diagnostic yield and low morbidity.

"La Turista": Incidence and Bacterial Etiology—*John D. Rouse* and *Richard L. Guerrant, M.D., University of Virginia School of Medicine, Charlottesville.*

Thirty-four (17 male, 17 female) of 51 members (67%) of the Yale Glee Club participated in a study of traveler's diarrhea (*turista*) during a 1-month tour of 12 Latin American cities in May-June, 1975. During this period, 25 of 34 (74%) developed acute watery diarrhea lasting an average of 5 days and usually not accompanied by fever, vomiting, myalgias, or bloody dysentery. Of 16 patients cultured during their illnesses, 6 (38%) were found to have enterotoxin-producing *Escherichia coli* in the stool by the Chinese hamster ovary (CHO) cell assay; no *Salmonellae*, *Shigellae*, or vibrios were isolated.

Cary-Blair semisolid agar (CB) proved much better than Buffered Glycerol Saline (BGS) as a transport medium. BGS failed to maintain viable aerobic coliform bacteria in 68 of 73 instances (93%) in which paired CB samples maintained these organisms for 1 to 6 weeks.

This study reaffirms the high frequency of *turista* among North American visitors to Latin America; toxigenic *E. coli* appear to be responsible for a substantial number of these illnesses. Considerable disparity between commonly used transport media was found, with Cary-Blair agar far superior to Buffered Glycerol Saline.

Life Threatening Bleeding Associated with Acquired Circulating Anticoagulant—*G. D. Qureshi, M.D., William C. Vennart, B.A., Herbert J. Evans, Ph.D., Peter W. Brown, M.D., Medical College of Virginia, Richmond.*

Acquired circulating anticoagulants, though infrequent, are usually found in patients with collagen vascular disease and are only rarely associated with severe life threatening bleeding. A 63-year-old man with adenocarcinoma of the esophagealgastric junction developed a circulating anticoagulant (inhibitor) 5 days following the resection of the tumor. The inhibitor activity peaked in 3 weeks and was associated with severe uncontrollable bleeding from multiple sites. Multiple infusions of plasma and clotting factor concentrates were unsuccessful. Following a 60% exchange plasmapheresis and steroid therapy, the inhibitor activity decreased significantly and later disappeared. Studies failed to demonstrate the presence of a collagen vascular disease. On incubation with normal plasma at 37°C, the inhibitor did not destroy selectively any clotting factor and thus behaved similarly to a "lupus type" inhibitor and was responsible for the abnormalities of prothrombin time, partial thromboplastin time, and stypven time. The inhibitor was nonspecific and was active against human, beef, swine, guinea pig, and dog plasma. It was nonabsorbable by $BaSO_4$ and was inactivated in vitro at 65°C for 30 minutes. The kinetic studies of the activation of prothrombin with Echis carinatus venom in presence of the inhibitor plasma suggested that this unique inhibitor specifically interfered with the conversion of prothrombin to thrombin, leading to decreased production of thrombin.

Long Term Cardiac Pacing: A 12-Year Survey—*R. S. Crampton, M.D., L. B. McGuire, M.D., S. P. Nolan, M.D.,* and *W. H. Muller, Jr., M.D., University of Virginia, Charlottesville.*

From 1961-1973, 319 patients aged 69 (1-97) years at first implant accumulated 896 paced years. Since 53% dwelt > 50 and 24% > 150 miles away, pacers were replaced at 5% predicted failure. Paced patients, 83% alive at 3 and 75% at 5 years, compared favorably with 88% and 80% for the Virginia age, sex, race matched unpaced population. Excluding death in the first 6 paced months, survival did not differ. Of 54 deaths, 19 were cardiac, 14 noncardiac, 11 unknown, 9 stroke, and 1 defective pacer. Male (188) survival, 83% at 3 and 75% at 5 years, exceeded female, 65% and 55%, despite better female survival in the general population. Of 38 nonwhites, 65% survived at 3 years, in contrast to 84% of 281 whites, suggesting worse outlook or case finding, or fewer meeting pace criteria for nonwhites. Survival decreased for each succeeding decade.

In 217 with A-V block, 83% survival at 3 years exceeded the 68% for 63 with sick sinus syndrome. With prior disease, poorer 5-year survival was seen in diabetes (42% of 40), heart failure (47% of 64), myocardial infarction (30% of 44), and stroke (17% of 21) than in white males (86% of 101) without prior illness. Paced survival is influenced by age, sex, race, sinus syndrome, and prior disease. These risk factors may help clarify decisions about the use and type of long life pulse generators.

Severe Electrolyte Disturbances (SED) Associated with Diuretic Therapy Utilizing Metolazone (M) and Furosemide (F)—*William D. Black, M.D., and Philip T. Shiner, M.D., Roanoke Memorial Hospitals, Roanoke.*

M in combination with F has been reported to be effective in patients refractory to other diuretic regimens. We have observed 6 patients treated with M and F who developed SED. Three patients had heart failure (HF), 1 had HF and renal failure (RF), and 2 had hypertension (H) and RF. The patients with H and RF were also being treated with other antihypertensives. Duration of therapy varied from 4 days to 2 months. Daily dose of M ranged from 2.5-10 mg. Daily dose of F ranged from 40-960 mg. Abnormalities (± SEM) included hypochloremia (74.1 ± 4.0 mEq/L), hyponatremia (128.0 ± 1.8 mEq/L), hypokalemia (3.0 ± 0.4 mEq/L), metabolic alkalosis (CO_2 36.6 ± 1.2 mEq/L), metabolic acidosis (anion gap 17.6 ± 1.1 mEq/L), prerenal azotemia (BUN: creatinine 17.6 ± 3.1), and hyperuricemia The patients being treated for H and RF were subsequently stabilized by decreasing the dose of F; however, in those with HF, M had to be discontinued. The patient with HF and RF required peritoneal dialysis to correct the SED.

Therapy with M and F may be associated with SED. The SED may be more persistent in patients with HF. There probably is a more significant adverse effect on renal blood flow in normotensive patients with HF compared to hypertensive patients not in HF. An apparent intraarterial volume contraction is produced. In addition, the SFD appears to have a more adverse effect on cardiac output in patients with previous cardiac dysfunction. This combination should be used cautiously in such patients.

Spontaneous Improvement of Renal Function in a Patient with Rapidly Progressive Glomerulonephritis—*Newell R. Falkinburg, M.D., introduced by Charles L. Crockett, M.D., Roanoke Memorial Hospitals, Roanoke.*

RPGN is an uncommon glomerular disease which is said to progress inexorably to renal failure. Because of its poor prognosis, treatment with anticoagulants, steriods, and cytotoxic agents either individually or in

various combinations, has been suggested. The efficacy of these agents remains to be proven in controlled clinical trials. We observed a patient with histologically documented RPGN who improved significantly without any specific therapy.

A 58-year-old female was admitted with hematuria. Laboratory evaluation demonstrated a moderately severe anemia, BUN 78 mg%, creatinine 6.8 mg% and creatinine clearance 7 cc/minute. An IVP revealed normal kidney size. A needle biopsy of the kidney showed changes typical of RPGN, and immunofluorescent microscopy revealed linear fluorescence of IgC and, to a lesser extent, B-1 complement. Fibrin was deposited in Bowman's space and in epithelial cell crescents. After discharge spontaneous improvement in all parameters occurred over 6 months. Presently BUN is 28 mg%, creatinine 1.9%, and creatinine clearance is 30 cc per minute.

This case is evidence that not all patients with RPGN quickly deteriorate. The common error of basing conclusions on poorly controlled observations is obvious. The therapeutic agents suggested for use in this disease may be hazardous. In addition, corticosteriods and cytotoxic agents may theoretically accelerate the deposition of soluble immune complexes by nonspecifically depressing antibody production. The use of these agents is therefore not advisable in RPGN until carefully controlled clinical trials substantiate their favorable effects on renal function.

Tickborne Tularemia in Virginia—*Richard L. Guerrant, M.D., Marion K. Humphries, M.D., Joanne E. Butler, B.S.,* and *Robert S. Jackson, M.D., University of Virginia Departments of Medicine and Ophthalmology, Charlottesville, and the Virginia Department of Health, Richmond.*

Tularemia is a potentially lethal infection. Serologic diagnosis requires 2 to 3 weeks, and cultural diagnosis is both difficult and hazardous. Consequently, the diagnosis and appropriate antibiotic therapy must be made on clinical grounds, frequently with a history of vector exposure. While rabbit contact in winter months is a familiar association, tickborne tularemia in summer months may be overlooked.

A graphic case of tickborne oculoglandular tularemia prompted a review of the seasonal and vectoral association of 106 cases of tularemia reported in Virginia over the last 13 years. A bimodal seasonal incidence was observed with winter (December) and summer (July) peaks. An associated vector exposure was noted in 82 (77.5%) of the 106 cases (rabbit: 55; tick: 20; squirrel: 3; cat: 2, fox: 1; raccoon: 1; unknown 24). The majority of cases occurring during winter months have been associated with rabbit exposure, while those in summer months are often associated with tick exposure. Each of the major types of illness classically described in tularemia (ulceroglandular, oculoglandular, typhoidal, and pneumonic) have occurred in Virginia in association with tick exposure.

Tickborne tularemia in the summer months is the typical pattern of tularemia seen in the western United States. A review of tularemia in Virginia reminds us that a history of tick exposure with any of the classical syndromes described should alert one to consider tularemia in the eastern as well as western United States.

The Use of Peritoneoscopy in Medical Oncology —*Kenneth Karb, M.D., Peyton Taylor, M.D., and Stephen Rosenoff, M.D., University of Virginia Hospital, Charlottesville.*

Twenty-four patients had peritoneoscopy performed at the University of Virginia Hospital from Jan. to Nov., 1975. Indications for peritoneoscopy included (1) diagnostic evaluation of hepatomegaly or ascites; (2) abnormal liver scan in patients in whom there was a high suspicion of occult malignancy; (3) staging evaluation of patients with malignant lymphoma prior to laparotomy; (4) evaluation of possible recurrent malignant disease in patients previously treated.

Diagnosis of malignancy was obtained in 11/24 (46%) patients, either by pinch biopsy of intraperitoneal lesions, by directed-liver biopsy, or by visualization of nonbiopsied mass. Physical findings, liver function tests, and liver scans were often clinically misleading. Information obtained at peritoneoscopy was useful and influenced the therapeutic approach in 18/24 (75%) patients. Serious postoperative complications were seen in 1/24 (<5%) patients. There were 3 minor complications and no postoperative deaths.

Peritoneoscopy is a useful diagnostic procedure for the medical oncologist. When performed by trained personnel, it has a high yield and a low morbidity.

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Calendar of Medical Events, 1976

February

Virginia Regional Meeting—American College of Physicians with Virginia Society of Internal Medicine—Charlottesville—February 14.

Pediatric Hematology—Oncology for the Practicing Physician—Sponsored by Department of Pediatrics, MCV—Richmond—February 18.

The Challenges of Ambulatory Care of Tuberculosis (Koch Centennial Symposium)—Sponsored by the Baltimore City Health Department—Hilton Hotel, Baltimore—February 20-21.

Virginia Chapter Annual Meeting and Scientific Program—American Academy of Pediatrics—Williamsburg—February 27-28.

"What's Wrong with My Eyes?"—Sponsored by the Department of Ophthalmology cooperating with the Departments of Family Practice and Continuing Education, Eastern Virginia Medical School, Norfolk—February 28.

Radiology of the G. U. Tract—Sponsored by Department of Radiology, MCV—Williamsburg—February 29-March 4.

March

Law Institute on Hospitals and Medicine—Sponsored by Department of Legal Medicine and Department of Hospital and Health Administration, MCV—Larrick Student Center, MCV, Richmond—March 5.

Recent Advances in Neonatology—Sponsored by Pediatric Continuing Education Program, University of Virginia School of Medicine—McKim Conference Room, Charlottesville—March 11.

Neonatology for the Practicing Physician—Sponsored by Department of Pediatrics, MCV—Richmond—March 18.

Twelfth Annual E. C. Hamblen Symposium in Reproductive Biology and Perinatal Medicine—Sponsored by the Department of Obstetrics and Gynecology, Duke University Medical Center—Durham—March 19-20.

"Challenges of Drug Therapy, 1976"—Sponsored by the American Academy of Physicians and the University of Virginia School of Medicine—Boar's Head Inn and McLeod Auditorium, Charlottesville—March 24-26.

29th Annual Stoneburner Lecture Series—Neurology for Primary Care Physicians—Sponsored by Department of Neurology, MCV—Richmond—March 25-26.

April

Pediatric Cardiology for the Practicing Physician—Sponsored by Department of Pediatrics—Pediatric Cardiology, MCV—Richmond—April 1.

International Surgical Conference—Sponsored by Department of Surgery with Department of Continuing Education, MCV—Williamsburg—April 4-11.

National Conference on Rural Health—Sponsored by American Medical Association—Hyatt Regency Phoenix, Phoenix, Arizona—April 8-9.

Recent Advances in Neurology—Sponsored by Pediatric Continuing Education Program, University of Virginia School of Medicine—McKim Conference Center, Charlottesville—April 8.

6th Annual Charles W. Thomas Lecture on Rheumatology—Medical College of Virginia, Richmond—April 13. Speaker: James B. Wyngaarden, M.D., Duke University, "The Newer Subtypes of Primary Gout."

Annual Joint Cardiac Symposium—Sponsored by the Heart Association of Northern Virginia—Arlington—April 21.

Pediatric Day—The Sutton Lectureship—Sponsored by Department of Pediatrics, MCV—Hyatt House, Richmond—April 22-24.

Virginia Surgical Society—Annual Meeting—The Homestead—Hot Springs—April 30-May 1.

Practical Advances in Medicine—MCH 9th Annual Symposium—Sponsored by Medical Center Hospitals and Eastern Virginia Medical School—Omni International Hotel, Norfolk—April 26-27.

(Continued next page)

Medico Legal Workshop—Sponsored by Office of Chief Medical Examiner, MCV Department of Legal Medicine, Virginia Society for Pathology, Inc. and Virginia Academy of Family Physicians—Virginia Baptist Hospital, Lynchburg—April 22.

Swineford Allergy Conference—Sponsored by the Department of Medicine, University of Virginia, Charlottesville—April 30.

May

"Recent Advances in Allergy" Symposium—The Homestead, Hot Springs—May 2-5. (Inquiries to Dr. Claude C. Frazier, 4-C Doctors Park, Asheville NC 28801.)

The 1976 Southeast Emergency Medicine Congress—Sponsored by the Southeast Chapters of the American College of Emergency Physicians and the School of Medicine Medical College of Georgia—Atlanta—May 3-5.

Recent Advances in Endocrinology—Sponsored by American Academy of Pediatrics—McKim Conference Room, University of Virginia, Charlottesville—May 6-8.

EEG Symposium—Sponsored by Department of Neurology, MCV—Richmond—May 17-18.

Annual Spring Forum for Child Psychiatry—Sponsored by Division of Child Psychiatry, MCV, and Virginia Treatment Center for Children—Richmond—May 21.

Clinical Rheumatology for the Practicing Physician—Sponsored by the Virginia Chapter of the Arthritis Foundation, Virginia Regional Medical Program, Medical College of Virginia, University of Virginia School of Medicine, and Eastern Virginia Medical School—Bonhomme Richard Inn, Williamsburg—May 21-22.

Annual Clinical Session—The Virginia Society of Ophthalmology and Otolaryngology—Williamsburg Conference Center—May 26-29.

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Continuing Medical Education . . . .

How to Accredit a Medical Organization

Criteria

I. Each organization desiring to have its CME activities accredited must have a written statement of purposes, goals and objectives. These statements should include recognition of the following:

A. The purpose of CME should be to facilitate the provision of quality medical care.
B. The goals and objectives should include updating of knowledge and skills; acquiring new knowledge, new skills, and new approaches to patient care; and increasing physician efficiency.
C. Effective adult education principles should be emphasized.

II. There must be an organizational structure that provides for authoritative leadership and an adequate budget to meet the stated objectives, with evidence of the following:

A. If there are by-laws, these by-laws must clearly designate an individual with the authority to create and maintain a level of educational activity commensurate with the CME needs of the organization as described in its objectives.
B. If there are no by-laws, there must be an individual who has been clearly delegated the appropriate authority to create and maintain a level of educational activity commensurate with the CME needs of the organization as described in its objectives.
C. The organization must indicate a mechanism by which the CCME will be kept informed of the identity of the individual responsible for CME activities.
D. The organization must specify the amount of money allocated to the CME budget. The mechanism or formula used to arrive at this budget must be explained.
E. There shall be a CME committee whose representation reflects the membership of the organization. This committee must meet at least quarterly and maintain minutes which include (1) committee attendance, (2) agenda, and (3) a summary of the discussion.

III. Organizations must be able to demonstrate the utilization of sound continuing education methodology, which includes involvement of the learner in all program phases—needs assessment, setting of objectives, program planning, and evaluation.

A. The organization must provide evidence of having assessed the CME needs of its members. The following may be used to determine needs:

- Patient care audit
- Peer review
- Other patient care studies
- Referral patterns
- Survey of medical staff

Developed for the Medical Society of Virginia by the Committee on Accreditation: T. Winston Gouldin, M.D., Norfolk, Chairman; Charles L. Crockett, Jr., M.D., Roanoke; James R. Scholten, M.D., Norfolk; Oscar A. Thorup, Jr., M.D., Charlottesville; David B. Walthall III, M.D., Richmond.

- Practice profile
- Mortality tables
- Morbidity data
- New advances
- Knowledge measure (tests)
- Simulation performance measure (patient management problems)
- Others (specify)

B. Activities must be based on instructional objectives commensurate with identified needs.
C. CME activities must be evaluated, and the mechanism used must be documented.

Maintenance of Accreditation

I. Documentation of attendance at all CME activities.

A. A standard form to be used in reporting attendance to CCME will be provided each accredited organization.
B. These forms are to be submitted within 30 days after the activity.

II. Notification of these CME activities will be expected in advance where the attendance will include more than local members. Program directors shall:

A. Contact the CME Office (804-353-2721) for clearance prior to setting a firm date.
B. Use a standard format in reporting CME activities to the MSV Continuing Education Office.

- Those programs received prior to 3 months in advance will be published in the Virginia Medical Monthly "Calendar of Events".
- Those programs received prior to the JAMA-CME publication deadline will be forwarded for publication.
- The CCME considers 6 months advance notice to be appropriate.

III. Program directors shall participate in the activities necessary to develop an effective statewide system of quality CME.

IV. CME activities are subject to being visited periodically by a representative of the CCME.

A. These visits are intended to provide a mutually constructive learning experience.
B. Each visit will be planned jointly by the Commission delegate and the CME Director.
C. The results of the visit will be reported to the CCME in writing.
D. Significant Commission recommendations will be reported to the program director.

V. Program directors must provide the CCME with a list of CME instructors utilized by their organization and a curriculum vita for each.

VI. The program director of each accredited organization shall have the responsibility of determining which of its activities shall be approved for credit.

Accreditation

I. Procedure

A. Any medical organization desiring to be accredited must complete an

application form. This form may be obtained by contacting The Medical Society of Virginia Continuing Education Office.

B. Arrangements may then be made for a site team visit.

C. Prior to the site visit the applicant must complete an Accreditation Survey Form.

II. Upon completion of the site visit the chairman of the team will submit a written report to the Accreditation Committee.

III. Accreditation Authority

A. The MSV accredits organizations, not specific courses or activities.

B. The Accreditation Committee of the CCME may grant full or provisional accreditation. Any other action must be taken by the CCME.

C. Accredited status begins on the date of survey, provided the Accreditation Committee approves the recommendation.

IV. When full accreditation status is awarded, the organization will receive an accreditation certificate of continuing medical education from the MSV bearing the seal of approval of the American Medical Association.

V. Accreditation Decisions

A. Full accreditation: The organization will be accredited for 4 years, at the end of which it must apply for reaccreditation.

B. Provisional accreditation: If the organization does not meet all of the criteria, a provisional status of accreditation may be granted if evidence is available that the deficiencies can be rectified within a designated length of time.

C. Non-accreditation: The organization fails to meet the accreditation criteria.

D. Probationary status: An accredited organization which fails to fulfill its obligations as described in the manual will be given a specific length of time to correct its deficiencies, during which time CME activities will be accredited.

E. Suspension: The organization which fails to correct its deficiencies during a probationary period will have its accreditation suspended. Any organization which has been suspended must reapply and complete the *entire* accreditation process.

F. Appeal process: The organization may appeal an accreditation decision in writing to the Chairman of the CCME. If the question is not resolved to the satisfaction of both parties the appeal process will follow the MSV by-laws.

VI. Cost of Accreditation

A. A $50.00 fee must accompany the application for accreditation.

B. Organizations seeking accreditation will share in the Site Survey Team expenses.

- Medical organizations with a membership of 50 or less will pay $150.00.
- Medical organizations with a membership of 51 or more will pay $300.00.
- The organization's share of expenses should accompany the Accreditation Survey form.

VII. All correspondence concerning accreditation should be mailed to: The Medical Society of Virginia, Continuing Education Office, 4205 Dover Road, Richmond, Virginia 23221. Dr. James M. Summers is the Director.

The Medical Advisor Looks at Medicare

DONALD L. BRUMMER, M.D.
Richmond, Virginia

AFTER SIX MONTHS as Medical Advisor to Medicare Part B for Virginia, I have been asked to wrote a short summary of my experiences, thoughts and feelings.

First, the people who work at Medicare. They are real people—interested, knowledgeable, well educated, thoughtful, and caring. After Mr. S.' wife, a Medicare beneficiary, died and he visited the office, both he and his original contact lady cried together in grief over his loss. This caring attitude prevails throughout.

Second, policy. As opposed to my original beliefs, and I think the belief of many practicing physicians, Travelers Medicare tries to pay as much as the guidelines allow, and to pay either the physician or the beneficiary as rapidly as humanly possible. A source of real misunderstanding on the part of many, if not most, physicians, as well as most Medicare patients, has to do with their not understanding the purpose of Medicare. Medicare is a form of co-insurance. Its purpose is not to pay physicians a fee for services, nor to pay for medical care for beneficiaries, but to help pay for care for the elderly and disabled. This is why, after determining that a service rendered was necessary and reasonable, a cost is calculated, and a percentage of this cost is paid after the patient has paid the initial deductible.

Third, difficulties. As many of you know, Part B Medicare uses codes derived from the 1964 California Relative Value Study. These numbers then are fed through a so-called "model system" computer, and a check is issued—unless one of the "gates" kicks the claim out of the computer, in which case it is then handled manually and put back into the machinery. It is true that Medicare has many problems with the computer, but everyone's problems would be greatly simplified if the person who does your billing would use the 1964 CRVS terminology, so the claim can be more rapidly processed, with less chance of delay caused by Medicare processors having to interpret into terms the computer can understand. An enormous amount of the efforts to obtain more information could be obviated by having your billing clerks understand the system and try to go along with it rather than fighting it.

Last, it is one of my purposes to try to fight the system for you by bringing your problems to the attention of both the carrier and the Bureau of Health Insurance in an effort to make things simpler and more up to date than they are now.

Doctor Brummer is Associate Professor of Medicine, Division of Infectious Diseases, Medical College of Virginia, Richmond.

* * * * *

Medicare at the Meeting

During the past few years, the Travelers Insurance Company's Part B Medicare claim department has sponsored an exhibit at The Medical Society of Virginia's annual meeting to make knowledgeable personnel available to Virginia physicians for Medicare related questions. Booth sponsorship has been worth the expense, as we have received numerous inquiries and have felt that we were rendering a service.

Two of the physicians who approached the Medicare exhibit expressed strong opposition to the profiling of data derived from billing procedures. Their objection was focused on the fact that Part B Medicare computerizes data relating to charges and procedures performed. Such data is computerized to comply with the Medicare law, which requires the carrier to develop a profile of customary and prevailing charges made by physicians. The developed profile becomes the basis for payment of both assigned and nonassigned claims.

Another physician objected to correspondence he had received requesting information as to how his office pathology procedures were performed, i.e., whether as a panel, individually by an automated method, or whatever. We explained to him that this information is needed to identify the proper procedure code for profile purposes.

At the convention, a Reference Committee recommended approval of a Resolution wherein Part B of Medicare would notify the physician of payment made directly to his patient on a nonassigned claim. Current regulations prohibit such disclosure. It is only when the physician and the Medicare beneficiary agree to the assignment of benefits provision that regulations permit it.

CURTIS J. KELLY, JD

Commentary . . . .

Concerning Medical Malpractice

> "Justice, I think, is the tolerable accommodation of the conflicting interests of society, and I don't believe there is any royal road to attain such accommodations concretely."
>
> Judge Learned Hand

DESPITE THE PLETHORA of information which has been published in the medical literature and by the lay press during the past several years, there is apparently still universal disagreement as to what is the true nature of the "malpractice crisis" in the nation as a whole and in the various states in particular. A serious student of the subject is forced to conclude that it is similar to the parable of Buddha in which the six blind men attempt to describe an elephant.

Perhaps the multiple solutions which have been forthcoming only confirm my proposition that we are fighting the wrong battle, at the wrong time, on the wrong field, against the wrong enemy, for the wrong reasons. Having attended multiple meetings on the national and state level where the participants have attempted to diagnose and treat the malpractice problem, I have recently had some "aftbodings" concerning the direction of our efforts.

The ad hoc Committee on Medical Malpractice of The Medical Society of Virginia under the tolerant and enlightened leadership of Dr. Raymond Brown has attempted to propose innovative legislation to ameliorate the conditions of medical practice in Virginia. Certainly these efforts are commendable and demonstrate a heightened awareness among physicians that there are some matters which are best not left to chance and the whims of a legislature heavily populated with attorneys.

Mark Twain is reputed to have once said something to the effect that there are two things which young children should not be allowed to observe . . . the making of sausage and the making of laws. Obviously he had some rare insight into the workings of the legislative process and the various power bases that come into play, often as not, to the detriment of the public at large.

The current situation is mainly the result of a rising tide of consumerism, pushed by a warm strong wind from the legal profession that encourages litigation in the expectation of inordinate material gain, not for patients' benefit, but for the legal practitioner who ultimately gets the lion's share of the malpractice premium dollar.

It is fairly obvious that the burgeoning of liability litigation and other consumer-oriented court actions will ultimately result in a profound involvement of attorneys in a new role —that of being held personally responsible for their professional competence. Just as surely as our day has arrived, their day will also come.

The professional person in the original scheme of things bought professional liability insurance to protect himself from adverse judgments resulting from the pursuit of his calling. This was true for architects, attorneys, physicians, and other professional persons.

We in medicine no longer purchase liability insurance primarily to protect ourselves and families from financial ruin. Through judicial manipulation and many "Robin Hood" jury verdicts we have been forced into the position of becoming the intermediary in a reparations system. We no longer purchase insurance coverage to protect ourselves. In fact, we are

purchasing patient compensation insurance at the present time.

The next logical consideration concerns how this situation has come about and what role regulatory agencies have had in sanctioning it. In theory, the Insurance Commissioner of Virginia has virtual autonomy in the oversight of all matters pertaining to insurance within the state. In this regard we are witnessing a public official, appointed, not elected, serving as a functionary for the State Bar Association.

It should be noted that the Virginia State Bar Association recently issued a statement to the effect that there is no malpractice crisis in the State of Virginia. At the August meeting of the American Bar Association in Montreal, a paper entitled, "The Medical Malpractice Crisis In Insurance: How It Happened And Some Proposed Solutions", and prepared by Thomas F. Sheehan, J.D., stated that there currently exists a crisis in Virginia as regards medical liability insurance.

It also is of interest that the Virginia State Bar Association paper totally ignored the problems of hospitals, nurses, allied health personnel and all interested parties except physicians. Certainly, their focus on physicians as the identifiable party to be attacked bespeaks the credibility of their meager effort. Regardless of the lip service paid to the inalienable rights of citizens to use (and misuse) judicial processes, a lack of mature social conscience shines through in this rather irresponsible document.

The upcoming meeting of the State Legislature probably will be the last opportunity to avert a catastrophe of health care in Virginia. If the public will is that physicians function as conduits for funds to finance a compensation system which has an overhead cost of approximately 80%, then let this be articulated by the General Assembly in clear terms.

Conceptually, a compensation system whose potential beneficiaries are each and every citizen should be funded by a general taxation or assessment, not by heavily penalizing that unfortunate segment of the population which requires expensive medical care each year. After all, those who have need of physician and hospital services are underwriting most of the malpractice costs. There are drawbacks to funding concepts such as no-fault compensation and funding by the Federal Government, which make them less than palatable solutions.

To be viable, a compensation system must be handled in a manner similar to Workman's Compensation, with its inherent restraints and controls in order to keep matters within realistic fiscal boundaries. Unpopular as this idea is to the legal profession, it would seem to offer more equitable treatment of patients than they now receive in our judicial system, which is not structured to deal evenly with matters of complicated medical practice (and other matters as well).

No system of compensation will be able long to survive if there are not stringent cost controls with recovery only for demonstrable injuries having permanent sequelae as determined by a panel of acknowledged experts. Nebulous concepts such as pain and suffering should be relegated to their rightful obscure place in such deliberations.

The establishment of such a system should be a paramount objective to be sought in the next legislative session. The constitutionality of such a proposal surely can ride on the coattails of prior legislation such as Workman's Compensation.

We should eliminate the concept of malpractice insurance, since it does not exist in the real world, and establish a system of patient compensation for injury incurred in the Health Care System. This should be managed at a state level for the ultimate benefit of society as a whole. This system should be funded by society (potential beneficiaries) and managed by the State of Virginia Insurance Commissioner. Physicians should get out of the insurance business (providing compensation insurance coverage for patients) and get back to practicing medicine.

Quincy A. Ayscue, M.D.

Suite 404, Medical Tower
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RIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

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ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Foot of patient with acute gouty arthritis as seen by conventional x-ray.



Scintiphotogram of same foot reflects inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal joint of the great toe of a patient with acute gouty arthritis. This increased uptake probably results from increased vascularity in the affected areas.

For a more detailed description of scintiphotography, see "addendum" at right.

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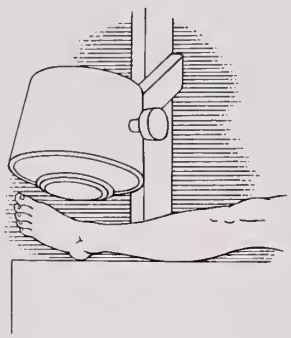
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For a brief summary of prescribing information, please see following page.

addendum

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Facts about Scintiphotography



In recent years a variety of radiopharmaceuticals have been employed to aid in the diagnosis of bone and joint disorders. The joint-imaging technique consists of injecting technetium polyphosphate intravenously, and imaging is performed with the scintillation camera two hours after the administration of the radionuclide. In general, for joint surveying, the shoulders, elbows, hands, wrists, knees, ankles, feet, and vertebral column are mapped. The entire scanning process takes approximately one hour. The criterion for a positive image is a higher concentration of radioactivity in a joint region than in adjacent nonarticular bone. In effect, each patient serves as his own control.

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in selected patients

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day, without corresponding clinical benefits; 2) careful instructions to, and observations of, the individual patient are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers, active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis, which may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, including dyspnea and asthma; angiitis; pruritus; urticaria; angioedema; skin rashes; purpura.

Ear Reactions: Hearing disturbances, deafness, tinnitus.

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Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

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In Favor of a Fight

PHYSICIANS have not become more slipshod and incompetent in the past few years. What is new and different is the increase in medical liability lawsuits, aided and abetted by some trial lawyers who get high contingency fees from extravagant claims. It is ironic that the physicians who have million-dollar insurance coverage to protect themselves are the very ones those attorneys go after.

Indiana has a good law which should go a long way to correct the situation. Their law has become a model for other states, and it is each state which should address this problem.

The Virginia Bar Association has come forth with statements in opposition to a bill based on the Indiana law, as one might expect, having witnessed the death of several "no fault" auto insurance bills in several Virginia General Assemblies. There are many attorneys in the General Assembly who find such legislation distasteful.

It is time for the gentlemanly physicians in the Commonwealth to roll up their sleeves and work and fight for laws which will justly compensate patients who may be truly wronged, without compromising good medical practices. The states that do this will provide good medical care for their citizens, and the states that don't will not. Physicians will move to states with good liability laws, or be forced out of practice by increased expenses and fear of financial ruin.

The attorneys in Virginia must realize that this government of the lawyers, by the lawyers, and for the lawyers may be detrimental to the health of all the people of the Commonwealth.

JOHN F. NOWELL, M.D.

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Report . . . .

Blueprint for a Successful Screening

CHARLES CUMMINGS, M.D.
Richmond, Virginia

THE RICHMOND Medical Society successfully completed the screening segment of its High Blood Pressure Screening Program by screening 4,480 persons in the East End (Church Hill) section of Richmond on May 24th, 25th, and 26th, 1974. The Society, an organization of black physicians, chose this project because of the high incidence and severity of hypertension among blacks and as a humanitarian gesture to a community from whence many of them came, live, and practice.

The target area, Church Hill, is a community in the eastern section of Richmond, consisting of 38,956 persons. It is 99% black. Although the target area was Church Hill, the entire city was invited to participate.

The project's objectives were to detect hypertensive persons and to alert the community to the dangers of high blood pressure. The policies and procedures for the project were established by the Society. Because the target community was predominantly black, the decision was made that anyone with a systolic and diastolic blood pressure above 140 mm hg or greater and/or 90 mm hg or greater respectively would be referred for followup medical management.

Through consultation with physicians practicing in the community, a system was developed for referring individuals who demonstrated abnormal blood pressure readings to sources of health care delivery.

Due to the saturated conditions of the city's health clinics, no new patients were referred to them. Physicians throughout the city consented to their being placed on a roster of physicians to which individuals without personal physicians were referred. Veterans, with the permission of the Veteran's Administration Hospital (McGuire), were referred to the VA Hospital. Indigent patients were referred only to the physicians of the Richmond Medical Society to receive their followup examination free of charge.

Only adults were screened, adult being defined as anyone sixteen years of age or older. However, upon parents' request younger individuals were screened. Blood pressure recordings were attained in private areas which lessened any patient excitement or uneasiness, and were taken on the left arm in a sitting position following a rest period.

Data was collected on the number of persons who saw a physician when they were referred by a health professional. Those patients who did not seek medical followup care after referrals, were contacted by letter encouraging them to do so. Due to the short duration of the program, these persons were contacted only once for followup.

Each screening team consisted of one consultant, two screeners, and two registrars. Consultants were physicians, pharmacists and dentists, who discussed hypertension with the screenees, referred screenees for medical followup, and were in charge of the team. Screeners were nurses, nurses' aids, medical corpsmen, and medical, pharmacy, and nursing students. Two-hour rotation of the screeners was necessary to assure their accuracy in obtaining blood pressure values using a stethoscope and a sphygmomanometer. Registrars were the lay public who assisted screenees in filling out forms and disseminating literature on hypertension. Orientation lectures were conducted for health professionals and the lay public separately to acquaint each group with its participation in the program. Health professionals, in addition to information concerning their role in the program, were reorientated to the physiology of blood pressure, the equipment in blood recording and how to use it, the meth-

ods of blood pressure recording, the factors which influence blood pressure and how to avoid them, and Korotkoff sounds.

TV news items, talk show interviews, coverage in the local newspaper, and radio personalities conducting remote broadcasting served to increase the enthusiasm and participation of the city and the target area. Educational materials were selected and developed for the black community, keeping in mind the degree of literacy of the majority of the adult population within the community. CIBA's CHEC program materials were also used.

Blood pressures were taken from a total of 39 east end sites. Screening was conducted from 15 sites on May 24th, 15 sites on May 25th, and 19 sites on May 26th. The Friday sites were open from 4:00 to 9:00 p.m. The Saturday sites were open from 9:00 a.m. to 4:00 p.m., and the Sunday sites were open from 10:00 a.m. to 3:00 p.m.

All screening sites on Sunday, May 26th were from churches, except for the site at Chimboraze Park. East End ministers had declared May 26th High Blood Pressure Sunday. Screening on Friday and Saturday was conducted from schools, shopping plazas, recreational centers, and drug stores within housing developments. Screening at shopping centers was conducted in office trailers on their parking lots. A mobile van from St. Mary's Hospital (custom built medical office on wheels), roved the community concentrating its coverage on barber shops, beauty salons, pool halls and out-lying areas that did not have a screening site. The mobile van's route of travel was known in advance. The van was equipped with a telephone, which made it easy to locate in an emergency—to send an additional team to it or send it to a screening site to help until a team could be sent. Each screening site had one or more physicians present. In addition, the physicians of the Richmond Medical Society closed their offices and brought their staffs into the field for the entire program.

The large number of screening sites necessitated the need for field coordinators. The social workers of the community took charge of this function. In teams of two, each group was responsible for three screening sites. Their responsibilities were to insure that data was collected properly, each site received equipment and materials, opened and closed sites, transported emergency teams and reported to headquarters every hour on general conditions of each site.

A few precedents in community affairs were set. Outstanding was the concerted effort of more than 400 volunteers who made the program a success. In addition to the Richmond Medical Society, the Licensed Practical Nurses Alumni Association participated as a group and served as registrars and screeners. The Association of Black Social Workers served as registrars and site coordinators. The staff of the Model Neighborhood Policy Board widely publicized the screening program and provided offices for a common post on the days that screening was conducted. The staff of the Church Hill Multi-Service Center distributed more than 10,000 flyers and served as site coordinators. The Red Cross and the Richmond Area Heart Association solicited volunteers. The Medical College of Virginia and the Richmond Academy of Medicine solicited volunteers. The Boy Scouts assisted in distributing fliers, and other social and civic clubs contributed registrars and site coordinators. The Richmond Urban League solicited sites, administered the program, compiled statistical data, and did all of the community organization. The CIBA Pharmaceutical Company provided flyers, pamphlets and other printed material. The General Medical Corporation provided 10,000 flyers for distribution and doughnuts and coffee for site workers. Twenty thousand flyers and 150 posters were distributed throughout the Church Hill community.

Results

After 13 hours of screening, 4,480 persons had been screened, of which 1,849, or 38%, had elevated pressures; 405, or 22%, completed followup, of which 293, or 72%, were hypertensive, and 227 were placed under treatment.

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To find out more about our comprehensive program contact the Co-Medical Directors, Dietrich W. Heyder, M.D., F.A.P.A., or Fathy A. Abdou, M.D., F.A.P.A., Human Resource Institute of Norfolk, Human Resources Building, 100 Kingsley Lane, Norfolk, Virginia 23505. Phone (804) 489-1072.

Editorials . . . .

The Doctor and Poet at War

"War knows no power. Safe shall be my going,
Secretly armed against all death's endeavour;
Safe though all safety's lost; safe where men fall;
And if these poor limbs die, safest of all."

—*1914*, by Rupert Brooke

READERS of the obituary notices of the *British Medical Journal* are often rewarded by these true biographical sketches, which are frequently exquisite examples of English prose, displaying a luminous quality in an otherwise somber area. Their fine literary workmanship is usually equaled by informative historical content, written with dignity and beauty.

A recent issue noted the death of Dr. W. J. McCracken, DSO, MC, MD. A reference to Rupert Brooke in the account of Dr. McCracken's service in the First World War opened a window of remembrance. "In 1915, he attended Rupert Brooke in his fatal illness and identified the pneumococcus responsible for the septicemia from which Brooke died."

The paths of the poet and Dr. McCracken converged aboard the Grantully Castle, which carried the Hood Battalion of the Royal Naval Division to the Aegean. Brooke became rapidly ill as a result of what was believed to be a mosquito bite on the upper lip, with subsequent pyogenic infection. The infecting organism was identified as a diplococcus, morphologically resembling pneumococcus. The patient developed a fulminating septicemia with a rapidly retrograde course, expiring aboard a hospital ship to which he had been transferred. Rupert Brooke, dead at 27, was buried in an olive grove on Skyros, in that "corner of a foreign field that is forever England". The Hood Battalion steamed away to the Dardanelles.

Rupert Brooke's familiar lines might well have been self-descriptive.

"Naught broken save this body, lost but breath;
Nothing to shake the laughing heart's long peace there
But only agony, and that has ending;
And the worst friend and enemy is but Death."

Rupert Brooke's poetry had an intense appeal for the younger generation of the years between the World Wars. He was a romantic figure with whom many young men could identify. *Second Best, The Beginning, The Hill, The Chilterns* all stand in welcome contrast to the arid doggerel of today. His verses sustained more than one young soldier in the Second War, and Brooke's lyrical gift remains a splendid thing to many of those who served.

Rupert Brooke's sonnet sequence, *1914*, which included "The Soldier", was published only a few weeks before his death. English youth, at that time, seemed to find expression in the line written by this handsome and romantic young man. Afterward, a British public, saddened and sickened by their losses, largely rejected his idealistic war poems. They said, somewhat bitterly, that the trenches in Flanders would have altered his attitudes had

he survived long enough to serve there, and even suggested that he was at fault for dying of infection rather than from a shell fragment!

Thus Rupert Brooke's memory faded from public awareness until interest was reawakened in 1964 by Christopher Hassall's biography of the poet. In spite of its failure to illuminate some aspects of Brooke's life, it is an excellent portrait. In it, Rupert Brooke emerges as a good officer who cared for his troops, trained them well, and had experience under fire in the Royal Naval Division's ill-starred Antwerp expedition of 1914. Hassall's volume, the subject of adverse reviews by that type of reviewer who doesn't read the material, nevertheless remains a faithful tribute to Rupert Brooke.

William J. McCracken volunteered immediately on the outbreak of the war in 1914 and was posted as Regimental Surgeon to the Hood Battalion of the Royal Naval Division at Gallipoli. There he sustained the first of two normally lethal wounds, a penetrating wound of the abdomen, in consequence of which he found himself in the hold of a ship with several hundred others. Having a supply of morphine tablets, he kept himself continuously sedated and thus survived. On the Flanders front in 1918, he suffered a severe head wound, and until the day of his death, so the account tells us, "he retained a sizable hole in his occiput". Throughout his military career, he displayed outstanding qualities of bravery and devotion to duty. After demobilization, Dr. McCracken located in Haworth, Yorkshire, where he spent the rest of his professional life as a family doctor. There he practiced medicine until his death on August 10, 1974, at the age of 86. He remained a doctor in the traditional family style, and is remembered with great affection by everyone for his personal care and thoughtfulness for his patients.

Perhaps all this is of doubtful relevance to these times, when nothing, nothing at all seems to matter, and values are hard to come by. But the fortuitous meeting of these two men at this juncture in history is significant, full of truth and meaning for all who cherish both service and beauty.

Rupert Brooke, "fair to see and winning in his ways", has been consigned to the category of "minor poets". It has been said that had he lived, he would have succeeded in government rather than literature. No matter. At an historically critical time, his *1914* sonnet-sequence, so expressive of love of country and need for sacrifice, sounded a call-to-arms, and gave comfort to those who serve in war.

And who better than Dr. McCracken typifies the best characteristics of the "island race"? From Gallipoli to the Ypres Salient he did his duty, took his wounds, and marched onward. A dedicated family doctor until, burdened with years, he died, W. J. McCracken's life stands as a shining example of integrity and dedication, contrasting sharply with the darkness of contemporary cynicism and indiscipline. Truly, he seized time by the forelock.

A long time ago, in a faraway sea, two men whose lives were of extraordinary richness and rarity, doctor and poet, met briefly on the eve of battle. Each kept the soldier's faith. And now both are, at last, dead.

William H. Kaufman, M.D.

The lines from *1914* by Rupert Brooke are from *The Collected Poems of Rupert Brooke* and are quoted by permission of Dodd, Mead & Company, Copyright 1915 by Dodd, Mead & Company, and Copyright renewed 1943 by Edward Marsh.

The Radiologist and His Fellow-Physicians

WHEN A PATIENT is short-changed for his radiologic dollar, one of the more likely causes is the unhealthy relationship between the radiologist and the referring physician. If the radiologist were magically transformed into the clinician, but retaining his radiologic "know-how", he would sit on the doorstep of his radiologist detailing the problems of his patient and the specific solutions desired. Later, he and the radiologist would review the examination with a brisk give and take, bringing the clinician's skills and awareness of the clinical problem to bear on the final interpretation. Thus, a rational diagnosis of cancer of the pancreas would be possible in the elderly anorectic lady who is losing weight, has a suspicious fullness in the left upper quadrant and a radiologically normal gut, but a little notching of the left ureter during the intravenous pyelogram: the notches represented the collateral portal return around the thrombosed splenic vein sitting atop the infiltrated pancreas. Scribbling the name of the examination on a prescription blank fails to give radiology the status of a consultative service it deserves for the welfare of the patient.

The deepest rung in purgatory must be reserved for the clinician who withholds vital clinical information to test the radiologist's objectivity.

Many a clinician does not know he is the single most important source of the radiologist's continuing education. How else can you explain his frequent lapses in giving the radiologist vital followups in clinical problems, either by word of mouth or by summons to the operating or endoscopy theaters? Only the clinician has the power to transform the radiologist's repetitive bungling into sound experience.

Nor can the radiologist be left "off the hook": one who avoids his clinical colleagues because he fears encounter, or is too busy or too bored, should be drummed out of the corps. Nor can he tolerate a technical and clerical staff who regards the visiting clinician as an intruder upsetting their comfortable routine.

The radiologist's specialty certificate does not automatically make him a consultant. The road to consultant status is long and rough, the climb is steep, and the top is never reached. New, difficult stretches are forever being added, the last being clinical immunology. The essentially contemplative nature of our specialty gives us time for this climb, more than most specialties, and if we fail to make it we are being unfair to the patients, our colleagues, and ourselves. Lister's words to his colleagues are especially applicable to us radiologists: "*You must be students, learning and unlearning till your life's end, and if, gentlemen, you are not prepared to follow your profession in this spirit, I implore you to leave its ranks and betake yourself to some third-class trade.*"

And Maimonides put it even more poetically: "*May there never develop in me the notion that my education is complete but give me the strength and leisure and zeal continually to enlarge my knowledge.*"

When the clinician fails to recognize radiology as a consultative service, his attitude can be traced to his mentor at the medical center, and ultimately to the radiology department of the institution where his mentor trained. A strong chief of radiology, finely attuned to the intricacies of clinical medi-

cine and pathology, soon communicates to the clinical staff that indeed he has much to contribute, and the more help he gets from the clinician, the more he can contribute. Only a weak radiologist would have allowed nurture of the doctrine: "You make the films, Doc, and we'll read them".

What can the radiologist do when confronted by this otherwise superbly trained young addition to the clinical staff, but trained in a center where the radiology department was never fully utilized? This young doctor, entering an alien environment, is more receptive at this time than at any other time in his professional life to help and advice tactfully offered. When shown illustrative material from the teaching file, he will see the wisdom of routinely combining the gallbladder and gastrointestinal studies, or the barium enema with the intravenous pyelogram. He will see the lack of necessity, even the harm, in specifying technical details of the radiologic examination (without prior consultation), such as specific views or kind of contrast material. He will see that when the radiologist is apprised of the clinical problem, he may offer a radiologic solution both medically sane and sparse of roentgens and dollars.

Such close relationship between the referring physician and the radiologist is necessary for the better care of the patient.

Christian V. Cimmino, M.D.

"I Am Counting on Each of You . . . ."

DOCTOR Cimmino's beautiful and appropriate tribute to Dr. Harry Warthen, published in these pages of the January issue, cannot be embellished by me, and I shall not attempt it. Suffice to say that the *Virginia Medical Monthly* has enjoyed twenty years of excellence and erudition under the direction of a distinguished physician, writer, educator, and scholar.

Now each month will challenge me, Doctor Warthen's successor, to maintain the standards established by him. This I hope to do with his continuing interest and support, as well as that of the Editorial Board and our managing editor, Mrs. Ann Gray, herself a recent successor to our gracious and competent Miss Spencer Watkins, who served so effectively for so many years.

But, most important of all, I am counting on the interest and support of each of you, our members and readers, to insure that this journal will be a useful source of knowledge regarding your Society and your profession.

W. Taliaferro Thompson, Jr., M.D.

Letters . . . .

To the Editor:

I am a member of the State Board of Medicine representing the Third District. In my now 9½ years on the Board, the podiatrists in Virginia have been very persistent in their efforts to avoid taking the same basic science examination as required of the other practitioners of the healing arts; also, in the past three years particularly, they have made efforts at the State Legislature to eliminate the requirement that they are not permitted to do surgery under general anesthesia. The present podiatry member of the Board persuaded the Board to reconsider this at their most recent meeting in Richmond on December 5, 6, and 7. The Credentials Committee reported to the Board that they recommend this requirement be eliminated from the Code of Virginia. Unfortunately, the Board voted affirmatively to pass this matter and recommended that the Legislative Committee of the State Board of Medicine consider this for new legislation. This action was taken in spite of very strong objections by me and Dr. George Carroll and Dr. Clarence Trower as this would require that any patient admitted to a hospital by a podiatrist would have to have a history and physical examination by an M.D., and that surgery carried out by a podiatrist would have to be under the direction of the Chief of Surgery of that hospital. This, of course, would only increase the cost of medical care to the individual. In spite of this, however, some members of the Board of Medicine approved this measure. I am sure the Podiatry Society of Virginia will be back with their efforts at the coming Legislature and will use this as a strong lever arm.

I believe that the members of the Board voting for this measure should be noted, along with the three who voted against it. Those who voted for it are: Dr. Robert C. Green, Jr., Winchester; Dr. Howard O. Mott, Arlington; Dr. Wallace E. Baker, Springfield; Dr. Edwin T. McNamee, Jr., Stuart; Dr. Walter A. Eskridge, Parksley; Dr. James M. Perry, Richland; Dr. Carroll H. Lippard, Lynchburg; Abraham Coster, C.P.M., Alexandria; James M. Walker, Chiropractic Member, Charlottesville; Burke M. Smith, Clinical Psychology Member, Charlottesville.

Those voting against the measure were Dr. George J. Carroll, Suffolk; Dr. Clarence B. Trower, Jr., Norfolk; and myself.

EARNEST B. CARPENTER, M.D.
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News . . . .

Virginia authors have been published in *Chest* for the second consecutive month. This time it's a trio from MCV's Division of Cardiology and Radiology: Drs. John H. Horgan, Michael C. Beachley, and Frederick D. Robinson, all of Richmond. Their article substantiates a further role for echocardiography by citing a patient in whom tricuspid valve prolapse was suggested by echocardiogram and confirmed by subsequent cineangiography. They note the problems in making this diagnosis employing right atrial pressure tracings and right ventriculography. For reprints: Dr. Horgan, Box 912, Richmond 23298.

* * * * *

Stanley D. Maoury, M.D., Manassas, is the new president of the Prince William County Medical Society, with these officers serving with him: Joseph Pugliese, M.D., Woodbridge, Vice-President; Robert Regan, M.D., Manassas, Secretary; Carol Shapiro, M.D., Manassas, Treasurer.

* * * * *

Faton Gashi, M.D., Falls Church, MSV member, is the co-author of an article recently published in the *Southern Medical Journal*. Its title: "Guillain-Barré Syndrome: Review of the Literature, Case Presentation, and Psychiatric Management." Dr. Gashi and his co-author, Dr. Margaret M. Kenrick, Washington, address themselves to the importance of total care of patients with Guillain-Barré syndrome, particularly the psychiatric management during the acute, recovery, and chronic stages of the disease. Described are 30 consecutive patients; more than 60% of them are documented as achieving satisfactory recovery.

* * * * *

Speakers at the Virginia Chapter American Academy of Pediatrics meeting and scientific program in Williamsburg on February 27 and 28 will be Dr. Vincent A. Fulginiti, University of Arizona; Dr. Thomas Rubio, Eastern Virginia Medical School; Dr. Francis S. Massie, Medical College of Virginia; Dr. Cecil B. Jacobson, George Washington School of Medicine; Dr. Raymond F. Ford, Charlottesville; Dr. H. Preston Boggess, Roanoke.

* * * * *

Dr. McLemore Birdsong, Charlottesville, will receive the annual award for outstanding contributions to medicine during the Annual Clinical Conference at Louise Obici Memorial Hospital, Suffolk, on April 14.

Eastern Virginia Medical School, Norfolk, is one of four medical schools over the country slated to grant the MD degree for the first time in 1976, the AMA medical education department reports. The other three are the University of South Alabama, Mayo Medical School and the University of North Dakota.

* * * * *

The Loudoun County Medical Society has elected new officers: John J. McGovern, M.D., president; Harold M. Jackson, M.D., Vice-President; Thomas Patrick McGorry, M.D., Secretary-Treasurer.

* * * * *

The Virginia Medical Society welcomes these new members:

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Abdul W. K. Durrani, M.D.

* * * * *

Antique glass collected by Dr. and Mrs. Richard Kennon Williams, Richmond, will be the special loan exhibit at the 1976 Antiques Show and Sale sponsored by the Woman's Auxiliary to the Richmond Academy of Medicine slated for February 13 through 15 at the Richmond Hyatt House. The Williamses' collection is of Liberty Bell pattern glass, made to commemorate the centennial of 1876. It has never been publicly displayed before.

The Antiques Show and Sale will benefit the Richmond Metropolitan Blood Service and the MCV Pediatric Endocrine Laboratory. Promised are 25 dealers from over the country, with an evening lecture by an authority on Chinese export porcelain. Show hours: 11 a.m. to 10 p.m. on February 13 and 14; 11 a.m. to 6 p.m. on February 15. Admission, $2. Advance reservations are required for the patrons' preview sale and reception for the evening of February 12; Mrs. Harry Thomas, Jr., 2508 Wyndham Drive, Richmond 23235, has these tickets.

* * * * *

Dr. Fitzhugh Mayo, chairman of the department of family medicine at the Medical College of Virginia, Richmond, was one of several physicians from over the country interviewed recently by *Internal Medicine News* for a feature article on rural health. The paucity of doctors in rural areas is a national problem in which Virginia shares; but Virginia is making progress in solving it, Dr. Mayo believes, with efforts in two directions. The first is the establishment of primary health care centers, linked to the state's three medical schools. (From Charlottesville comes a press release stating that the contract for the building of one of these centers was let early this year—to the tune of $6,579,000, and construction may already have started by the time these words are in print, with completion scheduled

for May, 1978. The Virginia General Assembly was a contributor to the funds for this center, though most of the money came from HEW.)

The other effort, according to Dr. Mayo, is the encouragement of residents to enter the primary care specialties and to locate their practices in rural areas, and there has been an unexpectedly excellent result from this program. Since 1970, MCV has produced 92 primary care physicians; and from 1974 to 1975, 21 of 30 residents said they planned to practice in rural areas. Special emphasis is placed on the inducement of Virginians from rural areas to enroll in the family practice residency programs, the theory being that they are more likely to return to their native locales to practice.

Virginia is fortunate in its progress in solving the rural health dilemma, the article points out, for in other states the problem presents no more than a guarded prognosis.

* * * * *

C. Robert Meloni, M.D., an internist in Alexandria, is the new president of the Alexandria Medical Society. His colleagues in office: James W. Preuss, M.D., Vice-President; Thomas J. Sullivan, M.D., Secretary; Eugene R. Jacobs, M.D., Treasurer.

* * * * *

Dr. Percey Wootton, Richmond, has been installed as President of the Richmond Academy of Medicine. Other new officers include Dr. Robert Edgar Mitchell, Jr., President-Elect; Dr. Charles M. Zacharias and Dr. James R. Wickham, Vice-Presidents; Dr. Carolyn M. McCue, Chairman of the Board of Trustees.

* * * * *

The Albemarle County Medical Society will be headed in 1976 by these Charlottesville M.D.'s: Dr. George D. Spence, President; Dr. Oscar A. Thorup, President-Elect; Dr. Arthur W. Wyker, Jr., Secretary-Treasurer.

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Obituary . . . .

Edward C. Paarfus, M.D.
Richmond

Dr. Edward C. Paarfus, clinical associate professor in the psychiatry department at the Medical College of Virginia, died December 26 of emphysema at his Richmond home. He was 53 years old. Doctor Paarfus graduated from MCV in 1955 and served his residency in surgery at Lewis-Gale Hospital in Roanoke, later practicing in Stuart. He then took a residency in psychiatry at MCV, finishing in 1965, when he joined the faculty. In addition to his membership in The Medical Society of Virginia, he belonged to the American Medical Association and the American Psychiatric Association, and was a fellow of the American Society of Abdominal Surgeons. During World War II he was a captain in the Marine Corps. Dr. Paarfus is survived by his wife, a daughter, three sons, and a stepson.

(Continued from page 128, "Familial Surgical Intracranial Infections.")

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(Continued from page 135, "Extrahepatic Lesions Causing False-Positive Liver Scans.")

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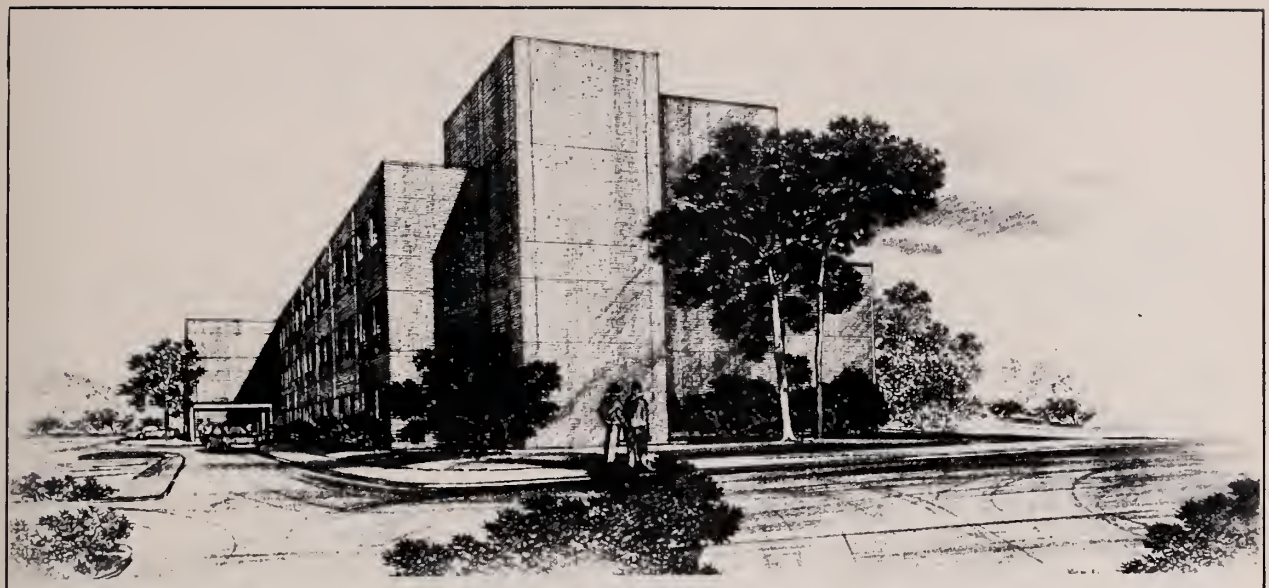
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Richmond Times-Dispatch

Sunday, July 15, 1973

New Hospital Planned

Plans to build a 66-bed hospital building and to renovate existing facilities have been announced by the Commonwealth Psychiatric Center here

Work on the new hospital, on the center's grounds at 3001 Fifth Ave., is scheduled to start within a few weeks. Completion of the project is expected in late 1974

Dr William M Lordi, director of the center, said the cost of the project, including development costs, renovation, site work and the actual construction will be more than $1 million

Lordi said work on renovating the present facilities has already started

He said three buildings—the Lor Berg Family Guidance Clinic, Janus Hall and Jacob Silverburg Academy—are to be improved The renovation will include interior improvements throughout all three, modernization of kitchen and dining rooms and installation of a gym, a workshop and an activity room

The new hospital building will be a two-story structure with 13 semi private rooms six lounges seven offices for doctors, an examining room, two main nursing stations and a complete dining room

Plans for the expansion have been approved by the Capital Area Comprehensive Health Planning Council, Lordi said The council is the official health planning authority in the Richmond area

The expansion is being made to meet a shortage of child and adolescent mental health programs in the Richmond area, Lordi said

Currently the center has an 18-bed hospital facility

Lordi said adolescent admissions to mental health centers have almost doubled in the United States in the last 10 years

Recent surveys have indicated that 10 per cent of all school aged children are in need of psychiatric help Lordi said He said half of these were serious enough to require in-hospital care

The Commonwealth Psychiatric Center is the only one in Virginia devoted almost entirely to child and adolescent mental problems The center primarily handles children aged 5 to 18 but also cares for adults as outpatients

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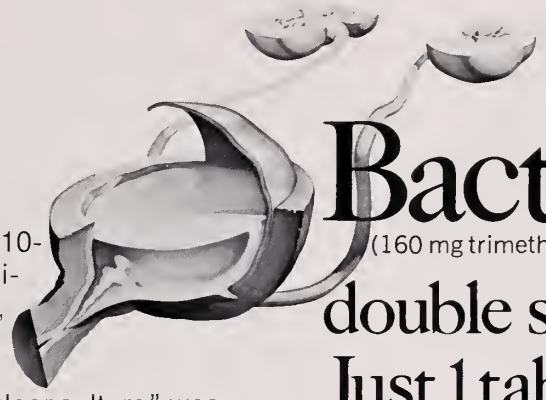
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10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions were mild (*e.g.*, nausea, rash), more serious reactions can occur with these drugs. See manufacturers' product information for complete listing.

Note: Bactrim single strength tablets were used in these clinical trials. However, studies have established the bioequivalency of Bactrim DS with the single strength tablets.

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NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

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Creatinine Clearance (ml/min)	Recommended Dosage Regimen
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Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

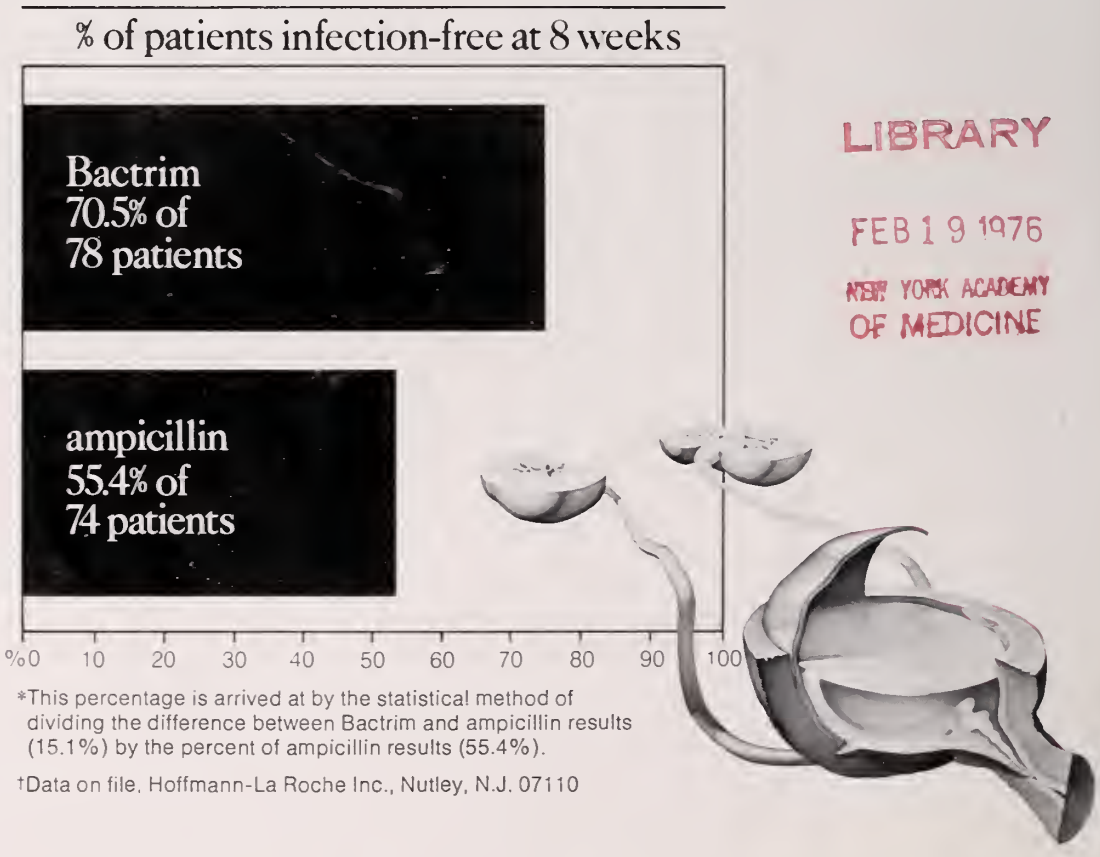
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*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, N.J. 07110

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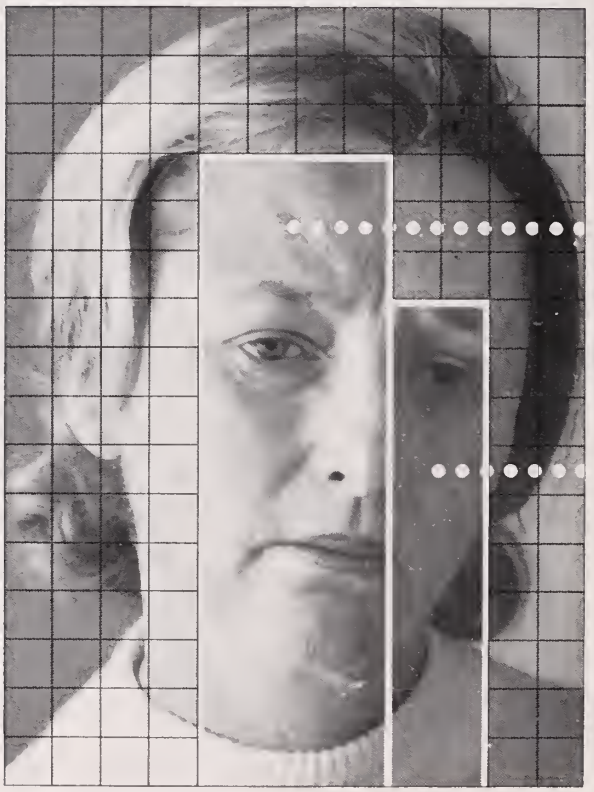
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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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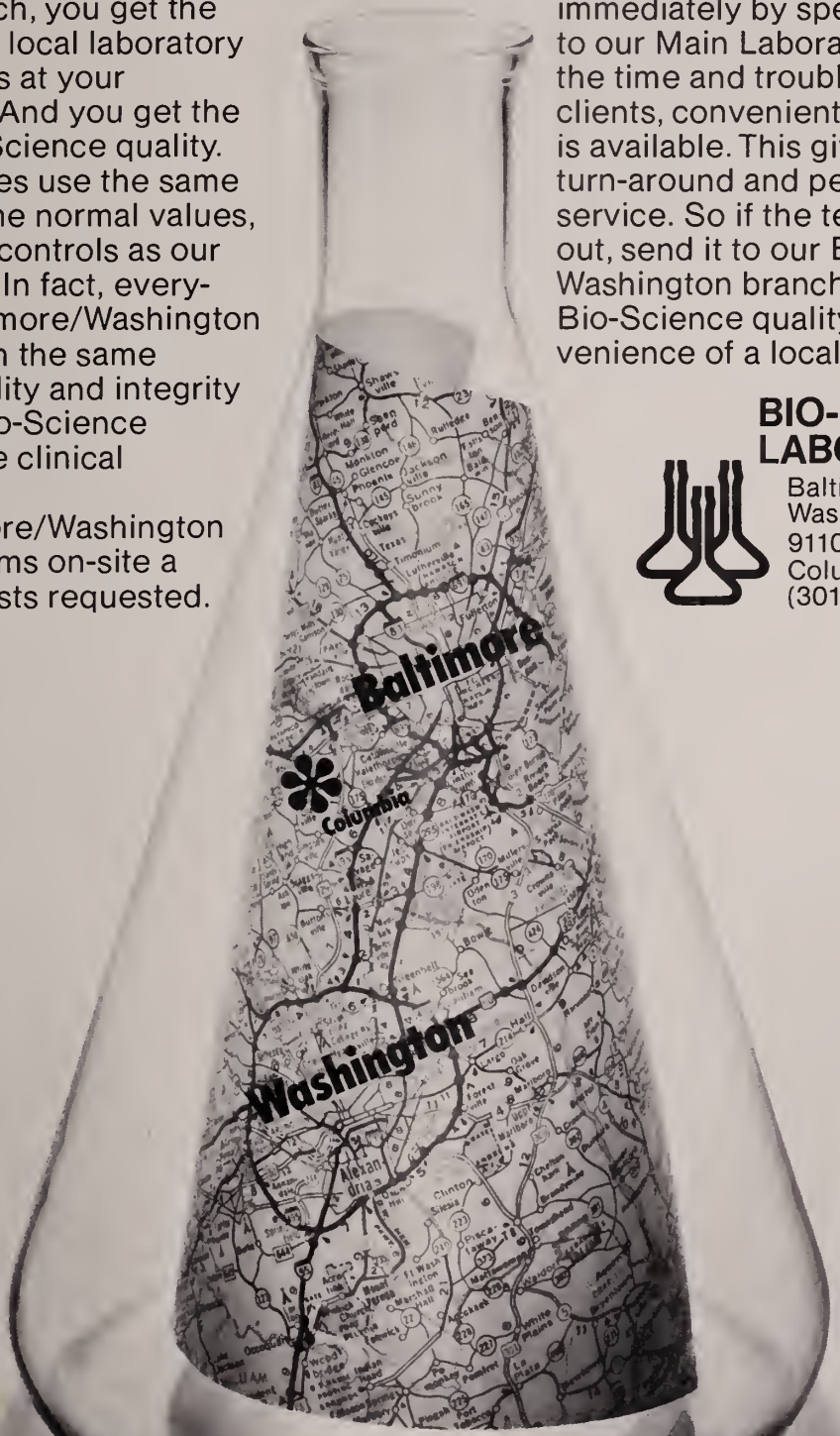
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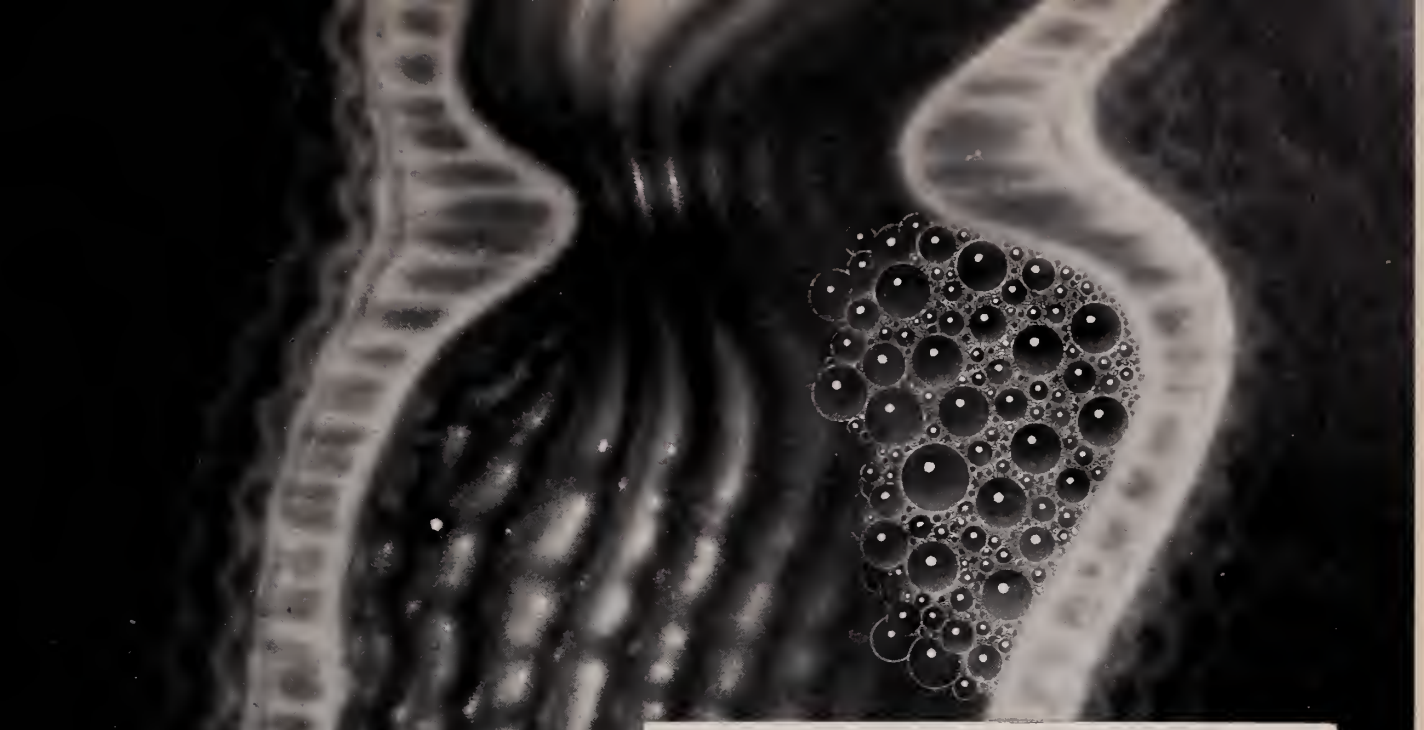


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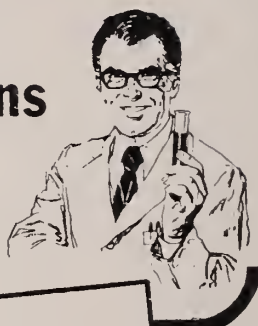
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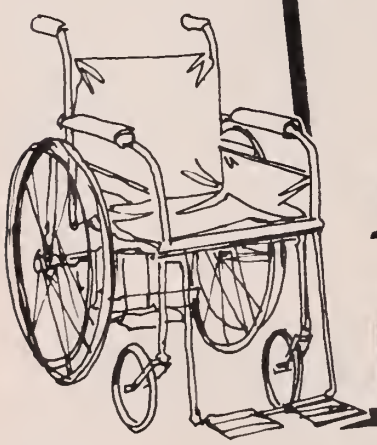
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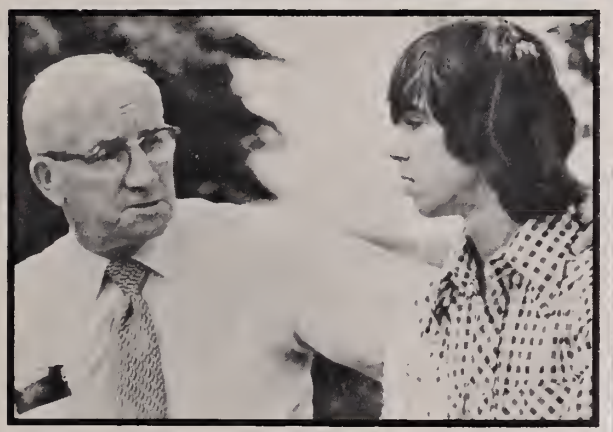


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Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

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Guest Editorials . . . .

The Continuing Medical Education Consortium: A Way to Go

OUR community, the Northern Virginia "suburbs" of Washington, D.C., is unique in many ways. It encompasses three medical societies, is geographically very close to the National Institutes of Health, is in reasonable proximity to three Washington medical schools which lie within a 15-mile radius and has strong emotional ties to the medical schools in Virginia. The hospital complement of this area, excluding the 16 District of Columbia hospitals, consists of two community hospitals with strong medical school affiliation, one community hospital of moderate size with no affiliation, four private proprietary hospitals, and a specialty community hospital with an approved residency program. The medical community itself has a similarly varied representation, from the superspecialist maintaining an active medical school teaching role, to the very busy family practitioner, who in many cases is isolated by his very activity.

On reviewing the requirements for accreditation of the Medical Society of the District of Columbia it was quite apparent that the small independent community hospital would have difficulty in setting up an accreditable program of continuing education. The usual departmental meetings, grand rounds, CPCs, and other staff conferences filled a need at the hospitals, and the occasional scientific programs held by the Alexandria Medical Society provided important information. However, these programs were not cohesive, were not readily assessible as to their effectiveness, and were usually poorly attended.

The goals for those of us concerned with continuing education in Northern Virginia, therefore, were 1) to make available a variegated, accreditable program with internal cohesiveness, with a potential for assessibility based in large part on a determination of needs as delineated by chart audit and stated needs derived from questionnaires; 2) to improve attendance both by providing programs of high quality and by instituting a requirement for continuing education credits as a requisite for membership in the Alexandria Medical Society. With these stated goals the obvious approaches were the formation of a consortium of the five unaffiliated hospitals and the Alexandria Medical Society to best utilize the facilities of the hospitals and the talents of their collective staffs to develop a cohesive program of continuing medical education, and the passage of a bylaw in the Alexandria Medical Society establishing a requirement for continuing education.

At the instigation of the Chairman of Continuing Education of The Alexandria Hospital and the Alexandria Medical Society, a meeting of Chairmen of Continuing Education of the five hospitals and the Medical Society was held and a mutuality of needs discussed. The consortium concept was referred back to the Boards of Directors, Administration, and Medical Staffs of all the involved hospitals and the Medical Society. Support of this Consortium was provided in letters of approval from all of the groups contacted. Application was then made for accreditation for AMA continuing medical education

Category I credits and was submitted to the Continuing Education Committee of the Medical Society of the District of Columbia, which was the closest local body approved for providing such accreditation at that time. Though it was still functionally in an organizational state, the Consortium had begun providing continuing education programs in the form of four full-hour symposia held on Saturday mornings. The subjects for these programs responded to stated needs or requests from the medical community, who had been sent questionnaires, and provided no measurement for assessment or effectiveness. The Consortium Board felt that the provision of an ongoing program covering recent advances in all fields of medical endeavor, with specific programs directed toward audit-elucidated needs, plus the development of a system of self-assessment to determine courses to fulfill demonstrated needs, would be the appropriate approach for our community. This concept was presented to the Accreditation Committee of the Medical Society of the District of Columbia, who approved it, with the request that a charter be established for the Consortium to guarantee continuity. A charter was created, and the Northern Virginia Consortium for Continuing Medical Education became the first such organization in Virginia to be approved for CME Category I credits.

One concept in the charter merits special emphasis: a mechanism was established for the acceptance of additional members in all categories. Thus organizations in the Northern Virginia community presenting occasional programs of a creditable quality could petition for affiliate memberships, while organizations with fully developed programs of continuing education could petition for full membership.

The Consortium's action committees include an Accreditation Committee, an Audit Committee, a Finance Committee, and a Program Committee. A Certification Committee will review the accomplishments of members who apply for approval of their continuing education efforts. The Accreditation Committee will review all programs and present its findings to the governing board for approval. Any protest of the determination of the Accreditation Committee may be brought to the full Board for final action. The Audit Committee (composed of the Chairmen of the Audit Committees of each of the member organizations) formulates, in cooperation with the Program Committee, criteria for audit assessment supported by education programs in reaudit, thus providing a primary means for assessment of continuing education. Criteria established by members of the Audit Committee for the major disease entities to be studied are presented to the individual medical staffs for their appraisal. The Program Committee, working with the Continuing Education Committees of the member organizations, is charged with devising a cohesive program based on need as demonstrated by specific physician requests and will develop programs covering all areas of medicine and surgery. The Program Committee also will work in concert with the Audit and Accreditation Committees in selecting a profiling and self-assessment system for physicians who request this service. (A recommended model for this is the program provided for the physicians of Wisconsin).

In addition to its other duties, the Consortium will work in concert with the regional PSRO in providing aid in audit evaluation and course prepara-

tion. It will provide help and direction for the PSRO area and will participate when possible in state-wide programs of quality. It will also invite support of and provide aid to local chapters of national organizations, such as the Northern Virginia Heart Association, Northern Virginia Cancer Society, etc.

Clearly, the physicians of the Northern Virginia community feel that continuing education is one modality for maintaining the high quality medical care that has been the hallmark of American medicine. The support of a Consortium and the insistence on mandatory continuing education are concrete evidences that our medical community of physicians is striving to make its learning experiences more relevant to its needs.

MELVIN D. SMALL, M.D.

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China: A Chance for Truth and Humanity

NOW that cultural and scientific relationships are opening up between the United States and the Peoples Republic of China, with the medical profession participating on both sides, it will be well to keep in mind the character of the regime with which these relations are being fostered and thus the value of the relations themselves.

The PRC regime is not a democratic regime. It is governing and molding no free society. Truth is not one of its values. No facts are publishable unless they square with the preconceived ideology. A regime more different from our own could not be imagined.

Still, the exchanges can serve useful purposes. Scientists and technologists, including those of the medical profession, have a basic mental process which, however subjected to indoctrination and however besieged by authoritarian guidance, is committed to seeking verifiable answers to questions and a testing of hypotheses. The curiosity of the scientific mind cannot be completely suffocated by dogma.

We have seen this in the case of the Soviet Union, where the authoritarian regime has gradually been confronted by the challenge of Soviet scientists, including the social scientists and literati who write of social questions in scientific spirit. These have been encouraged by their confreres in free societies, with scientific and cultural exchanges providing a transmission belt for this encouragement.

So, we trust, it will be in the case of the Peoples Republic of China. Since the Chinese communist leaders are shrewd people, one can expect that they are as well aware of this as anyone and will endeavor to keep all exchanges to a minimum. To the extent exchanges are permitted, one hopes that the medical profession will participate. It has much to offer the spirit of truth and humanity which, somehow, must be encouraged by all possible means to triumph in the relationships of the human race.

SMITH SIMPSON

4124 Downing Street
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Major Hepatic Trauma: A 6-Year Experience

MICHAEL SWANK, M.D.
Richmond, Virginia

In the past, wounds of the liver were considered fatal; but in recent years survival has improved considerably—to 75% in this series. Treatment is described, and areas for further study are discussed.

HIPPOCRATES stated that "a severe wound of the liver is deadly", and until the last half of the nineteenth century liver wounds were considered fatal in almost every case. The earliest case of reported survival was in the seventeenth century Hildanus, but it wasn't until 1870 that Bruns introduced hepatic resection for liver trauma. Years later, the mortality rate of all liver injuries in World War I was 67%; but during the United States involvement in Vietnam, this had fallen to 4.2% as a result of rapid transportation, early operation, improved surgical principles, and better postoperative care. Hepatic trauma remains a considerable problem in civilian surgical practice, with injury occurring in 39% of penetrating trauma to the abdomen and in 15.6% after blunt trauma. Mortality rates have been reported by many authors in the range of 9-13% after penetrating trauma and 26-28% following blunt trauma. A report in 1973 by Frye of 139 cases of blunt liver trauma revealed an overall mortality rate of 26%, and in the years 1966-1970 this rate fell to 16%. Payne in, a 2-year study at MCV (1966-67), found a 7.2% mortality rate in 42 patients after either penetrating or blunt trauma. Because of the increased frequency of all types of traumatic injury at the MCV Hospitals in recent years, we have undertaken a review of all cases of hepatic trauma in which major resection was undertaken.

Presented at the annual meeting of the Virginia Surgical Society, Williamsburg, May 2-3, 1975.

Case Material

At the MCV Hospitals, 20 cases of major hepatic trauma were reviewed in the years 1968-1974. All cases involved hepatic resection or attempted resection for severe injury. In this group, there were 18 males and two females with ages ranging from 6-59 years. Of these, 70% had injuries due to blunt trauma, and 30% were due to penetrating trauma. Five of the latter six cases resulted from gunshot wounds. One-half of these patients examined in the emergency room had blood pressure of 80 mm/Hg or less, and four of the five deaths in this series occurred in this group.

Operative Procedures

Eighteen of the 20 patients underwent hepatic resection, 13 having right hepatic lobectomy and five left hepatic lobectomy. Two patients died in the operating room while undergoing attempted right hepatic resection. One of these patients had a vena cava tear unsuccessfully managed by balloon catheter placement. Both were due to blunt trauma and presented with profound shock. Associated intra-abdominal injury was present in 50%. Transfusion volumes averaged 14 units of whole blood per patient, with the range being 2-45 units. Seven of the 18 patients had T-tube drainage of the common duct, usually considered to be controlled extrahepatic biliary drainage.

Results

Overall mortality rate in this series of major hepatic injuries was 25%. In the patients sustaining blunt trauma, the mortality rate was 21%; after penetrating gunshot wounds the rate was 33.3%. The small MCV series reported a similar 17% mortality rate in six resected patients during that 2-year period

(1966-1967). Major complications, including cholangitis, pulmonary complications requiring tracheostomy, GI bleeding, abscess, and coagulopathy, occurred in 11 of the 18 patients for a morbidity rate of 61%. In seven patients with controlled extrahepatic biliary drainage, there was a complication rate of 71%, compared to only 34% of the 11 patients without T-tube drainage. There was one patient in each group with severe cholangitis. There was no association in our series between the severity of injury and the decision for T-tube drainage. All patients who survived were followed from one to six years and none had significant late problems related to the liver.

Discussion

In Payne's 2-year study prior to this review, 14% of patients with liver trauma required hepatic resection. In this subsequent 6-year experience, resection was carried out in 9% of all liver injuries. Trunkey and Shires[1] reported resection in 53 of 811 cases, or 6.5%. The mortality rate of 21% with hepatic resection after blunt trauma is comparable to the 24-28% rate reported on other large series, which includes all degrees of liver injuries. Our mortality rate was 33.3% in patients requiring resection for gunshot wounds. Other large series report 9-13% mortality rate for all penerating trauma. But in this analysis, we have not included gunshot wounds which were minor or required minimal debridement of the liver. If these cases were to be included the mortality rate would be comparable at 12%.

In our overall series, mortality was correlated to the presence of shock and associated injuries. Patients who arrived in the emergency room with a blood pressure of 80 mm/Hg or less had significantly higher mortality rates. Mikesky and DeBakey[2] reported in 1956 that if the liver and two other organs were injured, the mortality rate was approximately 35%; and if three or more organs were injured in addition to the liver, it rose to 56%. However, in a more recently (1963-1971) reported series from Shire's group, the figures were 8% and 21% respectively. This of course may represent surgical improvement, and their study includes even minor liver injuries, which significantly alters mortality rates.

Survival rates can probably be increased if certain guidelines are followed in hepatic resection. The surgical procedure should be primarily directed at control of bleeding, removal of all devitalized tissue, and establishment of adequate external drainage. Many injuries to the liver are minor lacerations or involve minimal loss of tissue. These can be recognized by the fact that bleeding has stopped spontaneously at laparotomy; they can be treated conservatively with minor debridement and sump drainage of the liver bed. We prefer to leave lacerations such as this open to allow drainage. Hepatic resection is indicated for deep fractures and extensive lacerations of the liver. Adequate sump or dependent drainage via Penrose drains should be established in all cases and resection carried out along anatomic planes with careful hilar dissection if possible. It is known that up to 80% of the liver can be resected with survival so that aggressive approaches can be undertaken. Packing of the liver is generally to be condemned and results in bleeding, abscess formation, and hemobilia at later stages in the postoperative course.

The role of extrahepatic biliary drainage remains controversial. This was first proposed by Merendino in 1963 as a means to decrease intrahepatic biliary pressure and obtain follow-up cholangiography; however, there is evidence this leads to increased complications. Lucas and Walt[3] have shown in animal and clinical studies that biliary pressure is not reduced significantly by T-tube drainage. They also found in both retrospective and prospective clinical trials that there is a significant increase in mortality and morbidity associated with biliary drainage. Foster[4] had 18 patients with T-tube decompression and found no proof that they fared better than patients without it. All of the stress ulcer bleeding in the series were in the biliary drainage group. However, Frye reported the same 25% incidence of severe complications with or without T-tube decompression. Emerson and Stone[5] reported 31 patients with controlled extrahepatic biliary drainage without biliary fistula, and

11 with biliary fistula in 439 patients without decompression. In our series, there was an increased incidence of upper GI bleeding in patients with T-tube decompression, although the numbers are small and without statistical significance. We feel, therefore, that this question of biliary drainage remains unsettled despite many studies. It should probably be reserved for those cases in which there is definite or strong suspicion of common bile duct injury. One benefit from T-tube insertion is that subsequent cholangiographic evaluation of the remaining biliary tree is possible.

Permanent partial vascular occlusion of the liver by hepatic artery ligation is another area of some controversy. The portal vein supplies 70-80% of the blood and 50-70% of the oxygen to the liver. There have been numerous well-documented cases of proper hepatic artery ligation, or right or left branch ligation, with survival. If ligation is contemplated for control of bleeding, the results should first be tested by temporary clamping of the vessel. Ideally, the site of ligation should be proximal to a major collateral, that is, the gastroduodenal or right gastric artery.

Brittain et al[6] have reviewed this approach and report that ligation of the hepatic artery or one of the terminal branches in a patient with relatively normal hepatic function is not fatal in the otherwise uncomplicated case. We have not performed hepatic artery ligation in this series. Lucas in a recent symposium[7] reports 3-4% of his patients undergo hepatic artery ligation for continued bleeding. We believe that it may be a useful procedure in cases of uncontrolled bleeding after suture ligation or small resectional debridement. Mays, however, in the same symposium[7] advocates hepatic artery ligation for most cases of liver hemorrhage due to trauma. He has performed ligation in 85% of his cases, with 13 deaths in 52 cases.

In tears of the hepatic veins or the inferior vena cava, the use of catheters as temporary bypass conduits has been described. There have been some good results with these catheters, but Mays, Lucas, and Walt have been discouraged and prefer to approach the problem directly by suturing or ligation, after temporary control of hemorrhage.

Fortunately we have had only one instance of vena caval disruption in 20 cases, and the patient died after attempted use of the catheter. The patient sustained cardiac arrest during placement, which was described by the operating surgeon as prolonged. We feel, as do others, that perhaps the direct approach to the vena cava or hepatic veins is preferable.

Careful attention to postoperative care is vitally important in all cases of major hepatic trauma and these patients ideally should be observed in an intensive care unit. Hypoglycemia, hypoalbuminemia, bleeding diathesis, pulmonary care, and antibiotics are all important considerations. Obviously, we need to know more about liver function at the cellular level following trauma, about the hemodynamic alterations, and about the role of biliary drainage. We feel that in major hepatic trauma, when conservative measures have failed to secure hemostasis, as in deep fractures and extensive lacerations, aggressive resection can be done safely and offers the best chance for survival in this grave situation.

Summary

Twenty patients at the Medical College of Virginia Hospitals over a 6-year period underwent hepatic resection for trauma, with two operative deaths. The overall mortality rate was 25%. We feel that aggressive treatment by hepatic resection is indicated only in liver injuries where extensive fractures have occurred and hemostasis with adequate drainage cannot be accomplished by conservative measures. Further studies in certain areas, including controlled extrahepatic biliary drainage, hemodynamic alterations, and hepatic cellular function following trauma, are needed in order to reduce further the mortality and morbidity rates.

(References on page 238.)

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Parathyroid Surgery: Modification in the Behavior of Couples

FRANK L. BROCHU, M.D.
Salem, Virginia

A method is presented for the display of calcium and phosphorus values in primary hyperparathyroidism. The progress of the hypercalcemic state secondary to end-stage renal disease is also illustrated.

MANY approaches to the diagnosis of primary hyperparathyroidism have been devised. The newer techniques using parathyroid hormone assay remain costly, of variable reliability, and dependent upon difficult techniques of venous catheterization.[1]

After excluding various other causes of hypercalcemia, the diagnosis of primary hyperparathyroidism can be made with a high index of suspicion; hypercalcemia then becomes the principal reason for surgical intervention. In doubtful cases, with borderline elevations of serum calcium, one may wait and see.

Not infrequently, the surgeon has agreed to explore the neck, only to encounter a series of calcium values well within the normal range. If he is not aware of the expected variability in serum calcium and phosphorus in this disease, his confidence may be shaken. He may cancel surgery which should be performed. Worse, he may proceed with a neck exploration, but give up when an adenoma is not readily found on the basis that the diagnosis was wrong.

Failure to find an adenoma in the neck creates a difficult and dangerous problem for the patient. Each successive exploration is more difficult and has a greater risk of injury to the recurrent laryngeal nerves, as well as a higher risk of overlooking the adenoma. Thus, the surgeon should be skilled in neck exploration and must be convinced that there is an adenoma to be found.

Repeated determination of serum calcium level is probably the best method of establishing the diagnosis of hypercalcemia today.[2,3]

Method

Parathyroid adenomas were removed from 12 patients. One patient was subjected to neck exploration without detection of parathyroid disease. Two patients with end-stage renal disease had significant hypercalcemia; the course of this complication was unaltered by removal of all parathyroid tissue in one case.

On the basis of this experience, the method reported here was devised, to display multiple simultaneous determinations of serum calcium and phosphorus values. Using simple statistical parameters, groups of values which represent clinical stages of hyperparathyroidism can be illustrated easily. Patterns of changes in the calcium:phosphorus couples resulting from surgical intervention become evident.

The method consists of plotting individual values for calcium and phosphorus, or the mean values representing sets of determinations, on a graph having a scale of calcium levels on the vertical axis and of phosphorus levels on the horizontal axis. Single points on this matrix represent, simultaneously, a value for both calcium and phosphorus. The relationship between these two ions is thus always evident.

Figure 1 illustrates the method and shows calcium:phosphorus couples from a group of patients who do not have hyperparathyroidism,

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Presented at the annual meeting of the Virginia Surgical Society, Williamsburg, May 2-3, 1975.

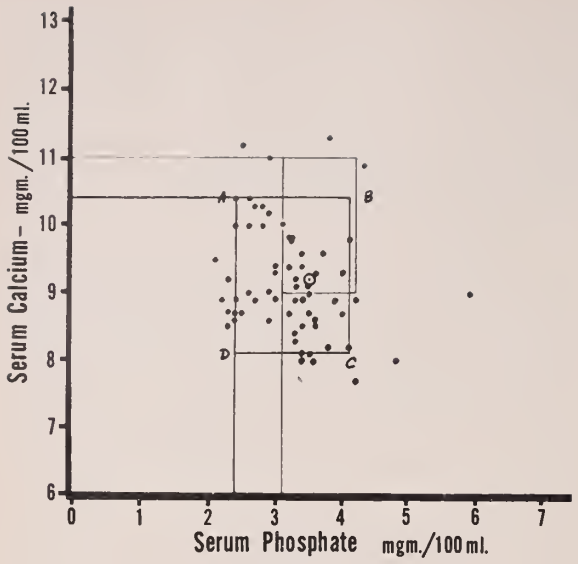


Fig. 1.

or renal disease. "Normal" limits can be displayed by horizontal and vertical lines. The upper set of lines represents the normal values in 1961 by one method. (These are retained to indicate calcium levels having particular significance to the surgeon.) The surround labeled ABCD is the normal for a more recent laboratory method and gives mean values with + or —2 standard deviations. A surround drawn free hand is useful to indicate the different sets

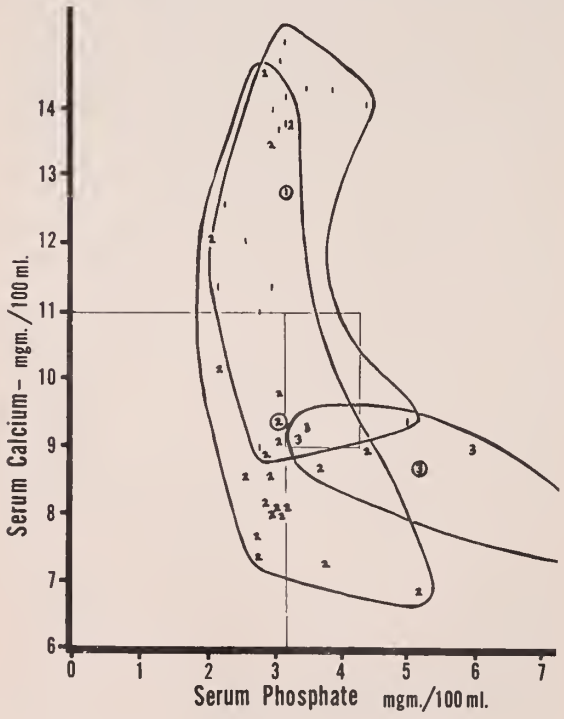


Fig. 2.

of couples representing eras in the patient's clinical course.

Display of these values on a calcium:phosphorus matrix is a useful technique to allow evaluation of the range of values. The mean value can be represented; the distribution about the mean is evident. After some experience with this method of display, the surgeon can "see" patterns characteristic of hyperparathyroidism. He also sees normal values within the perspective of the whole set of values, and is less concerned that these may have been reported most recently.

Phosphorus values may have clinical significance. Here they have the added usefulness of

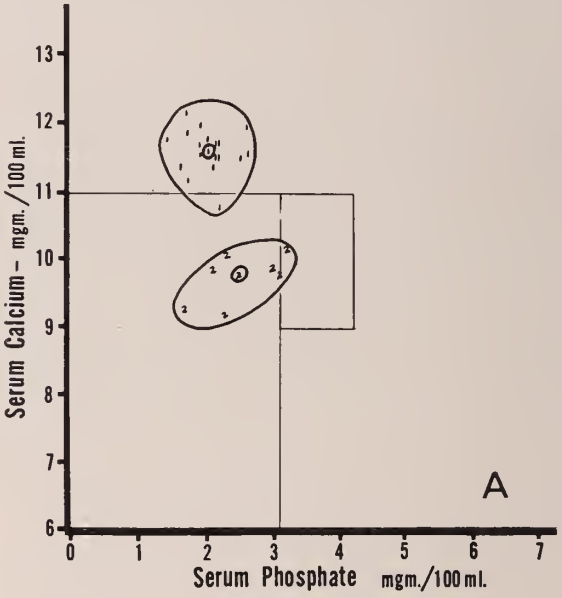


Fig. 3A.

allowing separation of the points of calcium values, on a basis other than "time." Plotting calcium values against time may require a horizontal axis representing many months, and may provide little help in visualizing the pattern of the calcium values.

Of the patients having classical hyperparathyroidism due to a solitary parathyroid adenoma, only one exhibited episodic function of the adenoma. This patient presented with episodic pernicious vomiting; his preoperative serum calcium values fell into groups, very high calcium values and normal values (*Figure* 2). The unusually long vertical range is evident, (preoperative values indicated by nu-

merals 1). His early postoperative values (numerals 2) reveal an unusually slow fall of values. Nevertheless, the late values (numerals 3) reveal a subnormal range a year or more after removal of an adenoma.

Eleven of the 12 patients with a parathyroid adenoma demonstrated calcium:phosphorus couples grouped about mean values. The degree of "fit" between the frequency distribution of calcium values and the "normal", or Gaussian curve, was very close. In such cases, the groups of values can be represented accurately by the mean values alone, provided the observer keeps in mind that there is always a distribution of actual values.

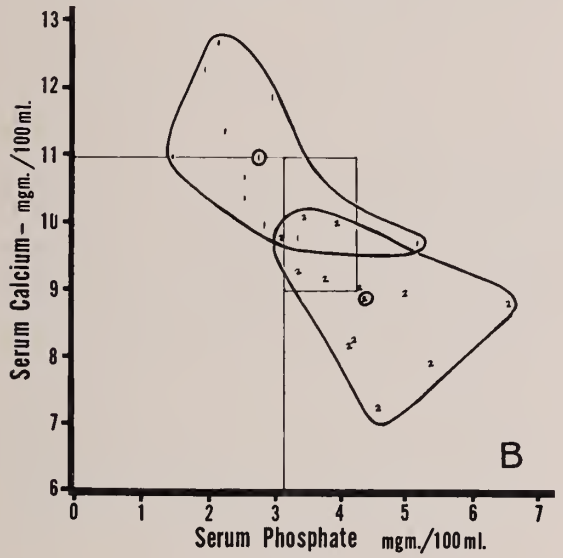


Fig. 3B.

Figures 3A and *B* show characteristic patterns of response to surgery in two patients having large solitary adenomas removed. Given sets of values (corresponding to preoperative, early postoperative, and late postoperative periods), one may connect the points representing the means to produce "vectors," which give a clear picture of the changing pattern of hypercalcemia, hypophosphatemia.

In Figure 4 can be seen vectors, indicating direction and extent of preoperative to postoperative change, in 11 patients having solitary parathyroid adenomas removed, with resulting changes in the calcium:phosphorus values. The arrows indicate preoperative to postoperative directions. Dotted arrows represent change to

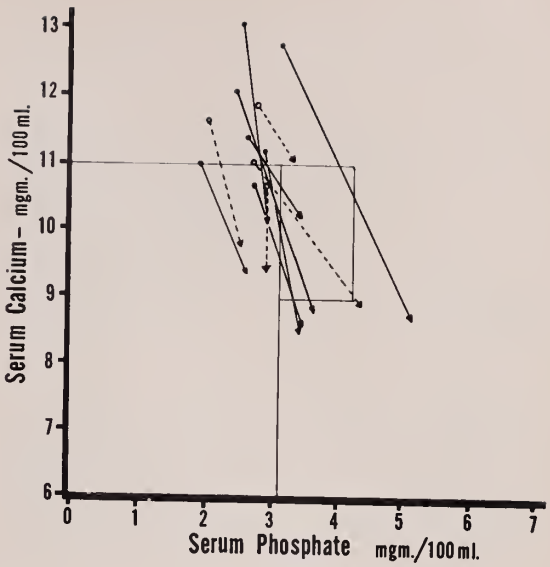


Fig. 4.

the early postoperative period (within one year); solid arrows indicate later postoperative values.

Figure 5 illustrates changes in the mean values of sets of calcium:phosphorus determinations for two patients dying of end-stage renal disease. Each set is for a hospital admission of several weeks or months, in the period before 1961, when chronic dialysis and renal transplantation were not available. The whole course in each case extends over a period of years. The patient whose values are shown in the upper graph underwent repeated removal

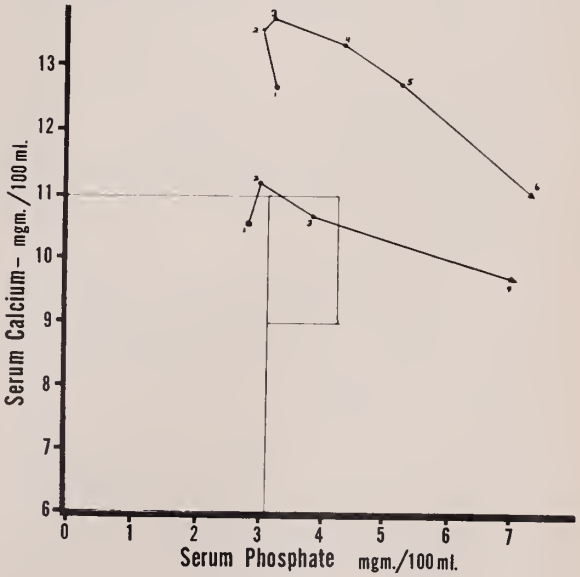


Fig. 5.

of "ademonas" of the parathyroid, total parathyroidectomy, and total thyroidectomy, without alteration in the course of his hypercalcemia. At postmortem examination, no parathyroid tissue was found. The patient whose course is illustrated in the lower graph had no surgery performed; at postmortem examination, extreme parathyroid hyperplasia was noted, together with an "adenoma of 4 cm diameter."

Summary

A method of illustrating the variability of serum calcium and phosphate values, using a matrix format, is presented. The great variability of both normal values and of values in the presence of primary hyperparathyroidism, is evident. The method of display is useful in presenting large sets of data concisely, and in illustrating changes in simultaneous values of calcium and phosphorus (couples) over time, or as a result of surgical intervention.

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Choosing a Candidate: How VaMPAC Does It

What are the factors on which the VaMPAC Board of Directors bases its opinion for candidate support? All decisions are hardnosed and pragmatic. The overriding concern of the VaMPAC Board is, "What is best for medicine?" In every election somebody wins and somebody loses. Every candidate will have the support of some physicians, and there will always be some who are unhappy with the Board's decision. The Board, after receiving the report of the VaMPAC district chairmen and after studying and debating extensively, bases its vote in general on the following objective criteria.

- Does the candidate have an honest and reasonable chance of winning? Bear in mind both VaMPAC and AMPAC resources are very limited; there is investment only in those candidates who have a real chance of success.
- Does the candidate have the general support of physicians in his congressional district? Are physicians interested enough in the candidate to help by raising additional money within the district?
- What are the actual needs of the candidate, and how serious are his needs? Again, because Pac resources are limited, the VaMPAC Board tries to make larger contributions to those campaigns where it may make the difference between winning and losing.

When considering support for an incumbent candidate, other factors come into the picture.

- Has he been generally sympathetic to and supportive of medicine since he has been in office?
- What are his committee assignments, and how important are these assignments to medicine? It is in committee that most of the work of Congress really takes place.
- Does the candidate have important party or other political positions?
- What is the legislator's seniority? His influence on other legislators and on current legislation can be very important.

With limited money to commit and all other factors being about equal, another fact must be considered.

- How well does the district stand in VaMPAC membership? Physicians who have not supported the VaMPAC program are certainly not in as good a position to ask for money for their candidate as those in districts with large VaMPAC membership.

Girard V. Thompson, Sr., M.D.
VaMPAC Chairman

Endoscopic Colonic Polypectomy

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THEODORE ADLER, M.D.
JAMES S. BERGER, M.D.
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A skillful operator can reach the transverse colon in most cases with the colonoscope. Experience in removing polyps with this instrument in described. This technique has the great appeal of avoiding laparotomy.

ENDOSCOPIC colonic polypectomy, recently described in the literature,[1] appears to be a safe, rapid, and uncomplicated method to extract intracolonic polyps, obviating the necessity for laparotomy. Since its description, it has held great appeal; although the question of its universal applicability, because of the skill necessary to perform colonoscopy, appeared to be open to question. This report will document our experience in a community hospital setting with the technique and will make suggestions to those considering adoption of the procedure.

Patients who are noted to have polypoid lesions in the gastrointestinal tract on one or more barium enema examinations are usually referred for consideration for endoscopic polypectomy. One barium enema, if it is of good quality, is usually satisfactory. This is in distinct contrast to the repeat barium enema almost always demanded by a surgeon preparing to do a laparotomy for a polyp. Our patients are hospitalized and their colons prepared with a mechanical cleansing agent, high colonic enemas, and a liquid diet. We routinely use nonabsorbable intestinal antibiotics to sterilize the colon. Patients are warned that complications include perforation and bleeding, and that they may, in fact, require laparotomy if complications occur. On the morning of the examination, the patients are brought to the operating room, having voided, with diazepam (calium) and atropine as premedication. Occasionally, heavier sedation is used, but general anesthesia has not been necessary. The colonoscope is then inserted and manipulated as far into the colon as possible. Usually the transverse colon is reached without difficulty. Between 5-10% of patients have proved difficult to colonoscope, and in these patients there is almost routinely a history of lower abdominal surgery, most often gynecological in nature. With the position of the scope confirmed by xray, the scope is then gradually withdrawn. A full, luminal view is obtained; when the polyp is seen, it is removed with a snare and cautery technique, familiar to most surgeons. By far the greatest difficulty is encountered in manipulating the colonoscope into the patient's colon; a variety of techniques to rotate the scope and uncoil the sigmoid colon, or to uncoil the sigmoid using a rigid stent, have been described. A mucosal sliding technique, or direct advancement of the scope under visualization of the lumen, is usually used until the transverse colon is entered. Occasionally, the right colon and the cecum can be visualized, but this is far from ordinary. The sigmoid, descending colon, and at least half the transverse colon will be visualized in 90% of patients without difficulty. The examination usually lasts about an hour and is occasionally accompanied by some cramping abdominal pain.

Our experience has been uniformly with the 110-cm Olympus colonoscope, CF, type MB, the CLE-3 light source, the Cameron-Miller snare, Model 80-7350, and the Cameron-Miller coagulator, Model 80-7910, with the wrist ground. Carbon dioxide has routinely not

Presented at the annual meeting of the Virginia Surgical Society, Williamsburg, May 2-3, 1975.

been employed and does not appear to be necessary.[2] Occasionally, an eccentric loop is desirable, and for this purpose, the Cameron-Miller flexible snare 80-7150 is easily adaptable.

Following polypectomy, the polyp, which lies free in the colon, is impacted against the end of the scope, suction is applied to it, and the scope is gradually withdrawn. Recovery of the polyp is usually not a problem with this technique. The ACMI instrument provides a second channel which can be used to grasp the polyp with a special forceps and aid in removal. The polyp is usually placed in formalin, and permanent sections are made so that the all-important stalk can be evaluated by the pathologist.

In this series, 28 patients were noted to have lesions on barium enema. Seven of these patients had no lesions on colonscopy. One patient had three polyps noted on the barium enema, but extraction was not performed since our equipment had not arrived. Twenty patients had a total of 26 polyps removed, 23 of which were benign adenomatous polyps and three were villous adenomas. The highest polyp removed was in the upper descending colon and the largest polyp measured 3 cm in diameter. There were three complications: two patients bled, one requiring transfusion; one patient, who had an enema 48 hours after a polypectomy, developed spiking fever and chills and ultimately Clostridia was isolated from his blood cultures. This responded satisfactorily to fluid and antibiotic management.

The three villous adenomas removed shared the unique property of having very tough stalks. Usually the snare is tightened around the stalk and kept in place for a period of about 60 to 90 seconds; then the cutting current is applied and the stalk sectioned rather easily. Little or no bleeding is noted. In sharp contrast to this, each of the villous adenomas required prolonged application of the current and considerable force to divide the stalk. One of the patients who bled had a villous adenoma. No bleeding was noted at the site of removal of this villous adenoma at the time of the initial colonoscopy. This observation may be of some value, since, if universally true, it will permit recognition of the potential for a lesion to be a villous adenoma, making it virtually mandatory that the polyp be recovered immediately, so that adequate pathologic examination can be performed. Nineteen patients had colonoscopy performed without polypectomy. Of these patients, seven were thought to have a polyp on barium enema and colonoscopy was negative. Two patients had positive barium enemas, one suggesting a questionable recurrent carcinoma after an operation and another suggesting severe diverticulitis. Both patients had carcinoma as proven on colonoscopy and by subsequent laparotomy, and this was missed on the barium enema. Ten patients were studied for rectal bleeding and had negative barium enema and air contrast studies done. In each of these patients colonoscopy was negative. We no longer consider rectal bleeding an indication for colonoscopy in patients with good quality normal barium enema and air contrast studies.

Obviously, the incidence of cancer is the underlying issue when dealing with polypoid lesions of the colon. In the series published by Shinya,[1] two of 166 adenomatous polyps had focal areas of carcinoma. In sharp contrast to this, nine of 29 villous adenomas had carcinoma in situ or superficial carcinoma. In mixed adenomatous and villous lesions, 12 of 63 polyps had findings of carcinoma in situ or superficial carcinoma. Only 11 of 303 polyps were frankly carcinomatous. Using these statistics, it is immediately apparent that the recognition of villous adenomata by the cutting characteristic of the stalk may be of significance, since these are the lesions at highest risk for malignancy. The treatment of such lesions has been nicely discussed by Shatney and Lober.[3] They feel that for a focus of cancer in a polyp, no further treatment is necessary unless tumor is noted in the lymphatic stroma, or there is a highly undifferentiated tumor, or there is a short stalk and tumor extends to the neck of the stalk. In their series, 10-18% of this latter group of polyps were shown to develop metastasis.

Sessile polyps are somewhat more of a problem, but these same authors suggest piecemeal

resection below 1½ cm in size and laparotomy for lesions above this size, since 10% show invasive carcinoma.

The ease of endoscopic polypectomy coupled with ready patient acceptance makes it a procedure which should be considered by surgeons interested in colonic disease. A study at the Peter Bent Brigham Hospital[4] compared the cost of polypectomy in time lost as well as dollars, using a retrospective analysis of open versus closed techniques. These findings show a 66% reduction in dollar cost to the patient without a change in surgical fee, and a reduction of perihospital morbidity from 28 to two days.

From every feasible standpoint it would appear, therefore, that endoscopic colonic polypectomy is a desirable therapeutic tool. Surgeons seeking to learn the technique can usually find someone skilled enough with the scope to demonstrate its use. Institutional purchase or lease seems the wisest choice, unless exceptionally high use of the equipment is anticipated. To that end, Shinya has shown that 92% of polyps were within reach of the short (110 cm) colonoscope; therefore, purchase of the shorter instrument is strongly recommended. With experience, facility is gained in the technique of colonoscopy, and endoscopic polypectomy becomes a viable alternative to laparotomy with its attendant morbidity.

Conclusions

This paper details our experience in a community hospital with endoscopic colonic polypectomy. We were unable to colonoscope about 5% of our patients; and in almost every instance, the patient had had prior low abdominal surgery. It appeared that the sigmoid colon was not mobile enough to telescope easily on the colonoscope. We noted that villous adenomata seemed to have a very tough stalk; difficulty in sectioning the stalk of a polyp should suggest immediately the diagnosis of villous adenoma. In our experience, the most technically difficult polypectomy was done just beyond the splenic flexure and at the apex of the sigmoid colon. We feel that the short scope is almost always adequate for polypectomy. We urge open resection for large sessile lesions, but would not hesitate snare resection of a small lesion.

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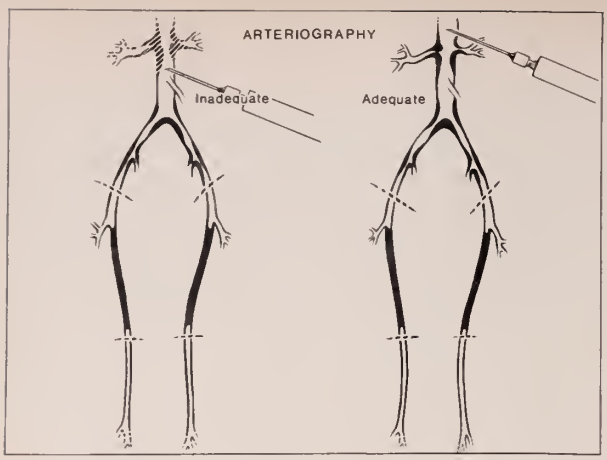


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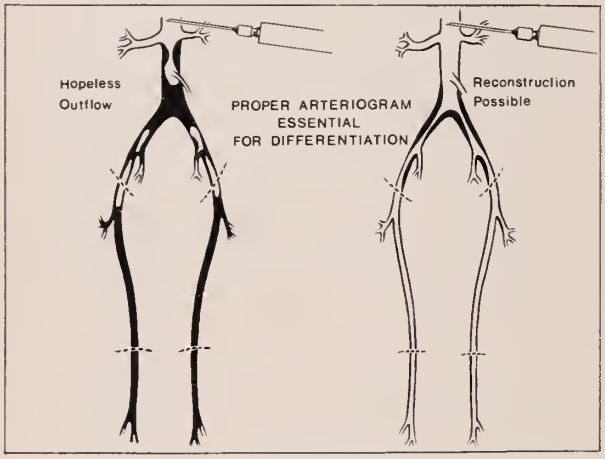


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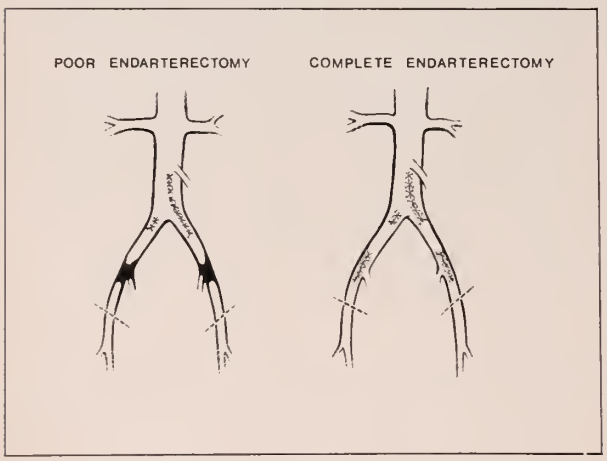


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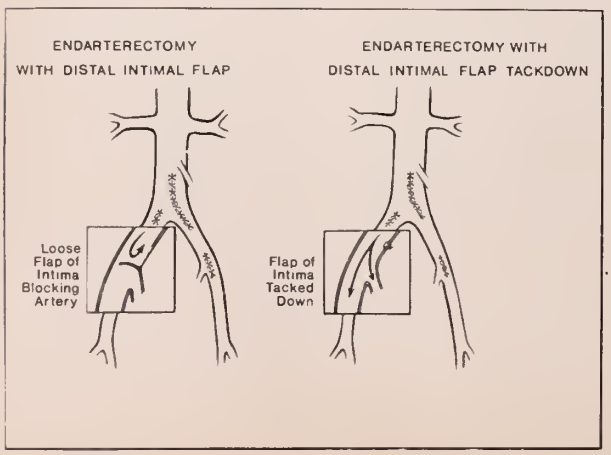


Fig. 4.

Reconstructive Surgery for Aorto-Iliac Occlusive Disease

LEVI OLD, JR., M.D.
THOMAS LANE STOKES, M.D.
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ALTHOUGH the basic principles of vascular surgery were established in the early 1900's by such pioneers as Rudolph Matas and Alexis Carrel, progress was only gradual until the 1950's, when the pace began to escalate dramatically. Many vascular surgeons active today were already in the formative years of their surgical careers as modern blood vessel surgery began its rapid development toward its present status, that of a mature discipline in its own right.

Progress in the field has been extremely fast, especially when measured against the slower, well documented advances in such areas as, for example, biliary tract or colon surgery. The inevitable complications encountered in any relatively new field have frequently outrun full coverage in the literature. Often, either avoidance or management of such difficulties has been learned by trial and error rather than by more traditional methods. At the same time, rapidly accumulating research and clinical experience have, in a relatively short period, produced a body of firmly established principles which offer better prevention, more accurate diagnosis, and more successful treatment than would have been possible at any earlier time.

During the evolution of arterial surgery, aorto-iliac occlusive disease has been treated by sympathectomy, endarterectomy, patch grafts, resection and graft, various short grafts, and aorto-iliac grafts. In the past few years reliance has increasingly been placed on aorto-femoral piggyback bifurcation cloth grafts.

Consider a typical patient, who presents with leg ache. Initial evaluation may suggest that arterial insufficiency is the culprit and that referral to an orthopedist, a neurologist, or other specialist is unnecessary. If lesser measures such as stopping smoking and good foot and leg care do not seem adequate, the patient is hospitalized for arteriography. This and other vascular workup may suggest conservative therapy; but if the need for surgery is confirmed, then a full general study is carried out.

Arteriography of the highest technical quality and completeness is essential to the selec-

tion and preoperative evaluation of all surgical candidates suffering from aorto-iliac disease (*Fig. 1*). The modified Seldinger technique of intraaortic introduction of a flexible catheter in conjunction with a rapid cassette xray film changer is helpful in visualizing the inflow from the upper abdominal aorta just below the diaphragm well down into the outflow through the calf vessels bilaterally.

Rarely, arteriography may show that reconstructive surgery is impossible (*Fig. 2*). However, as Connolly has recently popularized, profunda femoral arterial reconstruction itself is at times very helpful. Superficial femoral arterial occlusion is usually improved by reconstructive surgery, or it can be managed later by femoro-popliteal vein bypass graft.

Controversy continues over endarterectomy versus bypass graft or combinations thereof. If endarterectomy is used, it must be thorough (*Fig. 3*).

Many problems arise with endarterectomy alone or in association with grafting. One vital technical point is that the distal end must be smooth and adherent without allowing an intimal flap to remain (*Fig. 4*), thus inviting thrombosis.

With increasing knowledge of the frequent problems encountered with endarterectomy, the bypass principle has understandably become more attractive. Although transverse incisions may be used, the standard long paramedian is satisfactory (*Fig. 5*). Because of the late distal iliac occlusion, it seems better to carry the lower ends of the graft to both femorals; therefore, bilateral groin incisions are needed despite their known propensity for complication.

The abdominal aortic dissection is accomplished, and the upper aortic clamp is placed just below the visualized and protected renal arteries and left renal vein (*Fig. 6*). An additional large clamp assures distal and posterior control without extensive dissection. A small clamp is placed on the inferior mesenteric artery. The smaller sized cloth prosthetic bifurcation graft functions adequately and is easily and rapidly secured to a window in the patent or endarterectomized anterior upper abdominal aorta. The graft is carried through the usual retroperitoneal retroureteric tunnels and is then inserted into the anterior wall of the common femoral artery just at the profunda femoral artery origin.

The finished grafting (*Fig. 7*). Only rarely

Fig. 5.

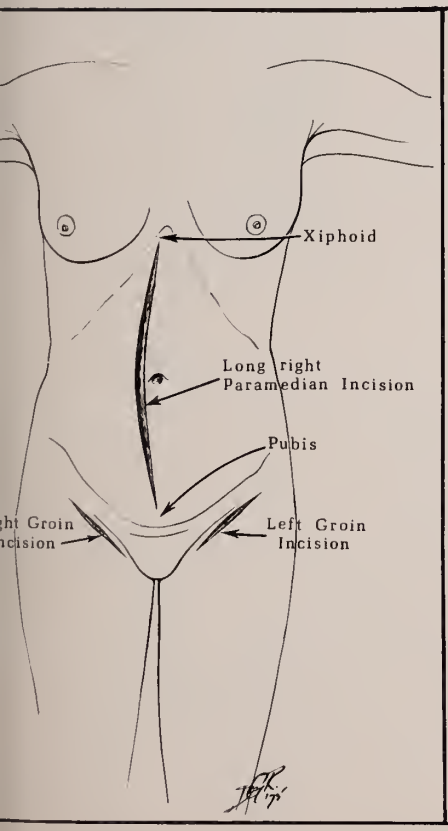


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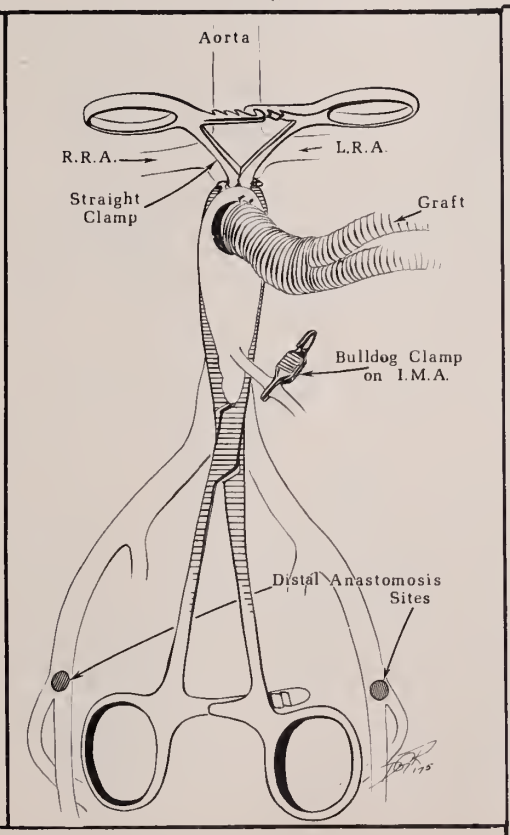
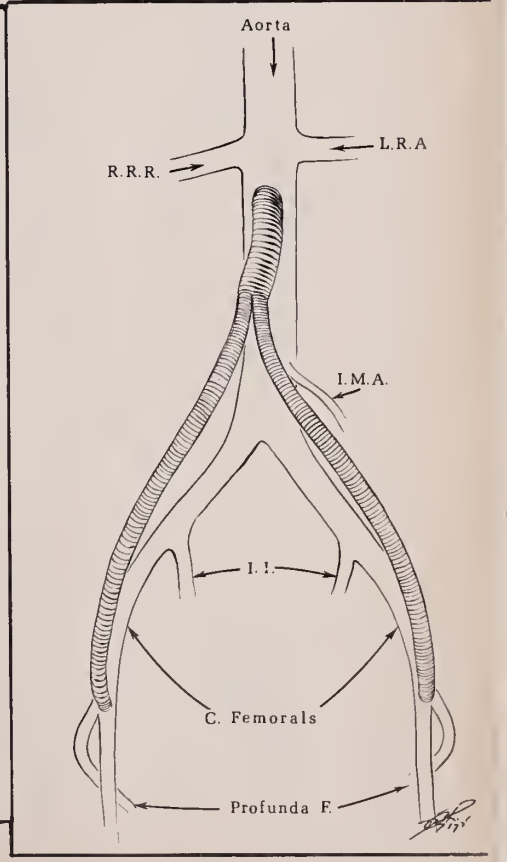


Fig. 7.



Presented at the annual meeting of the Virginia Surgical Society, Williamsburg, May 2-3, 1975.

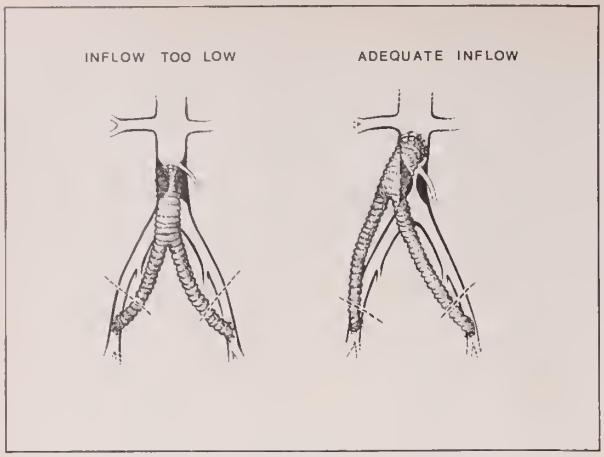


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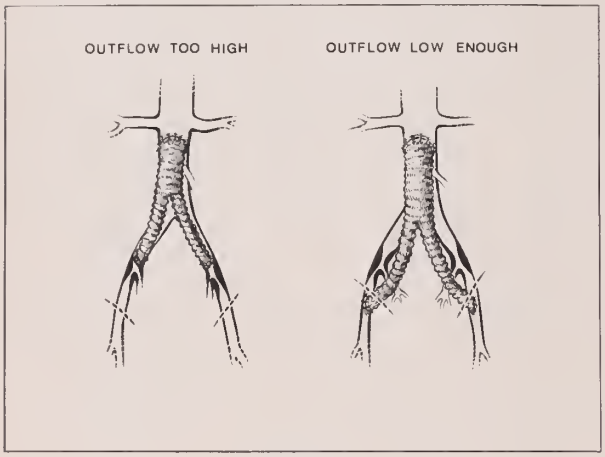


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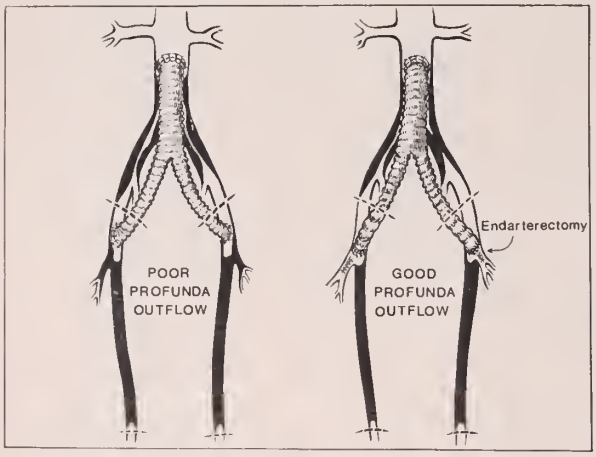


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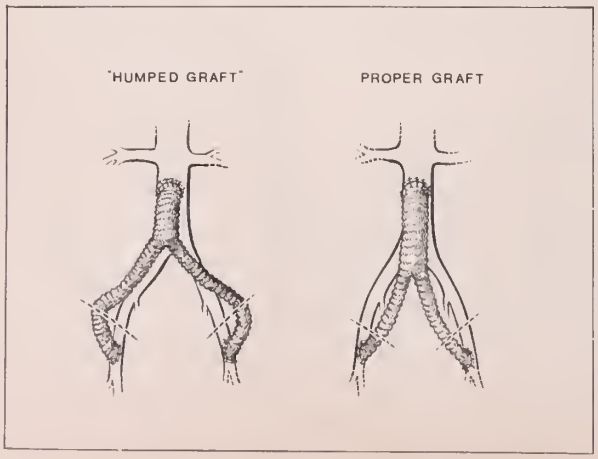


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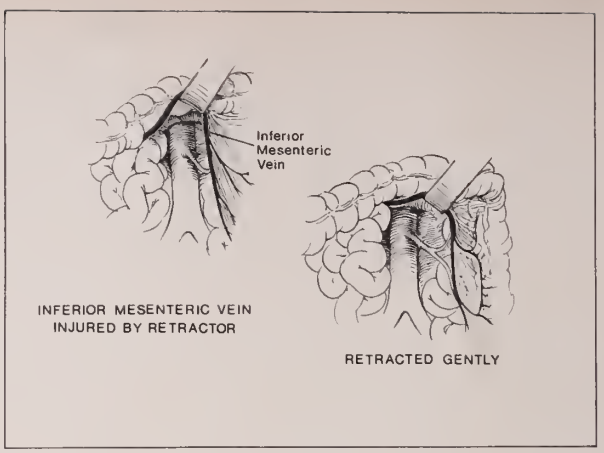


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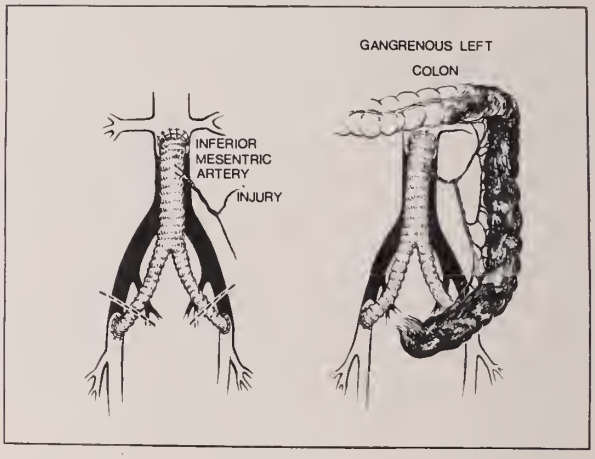


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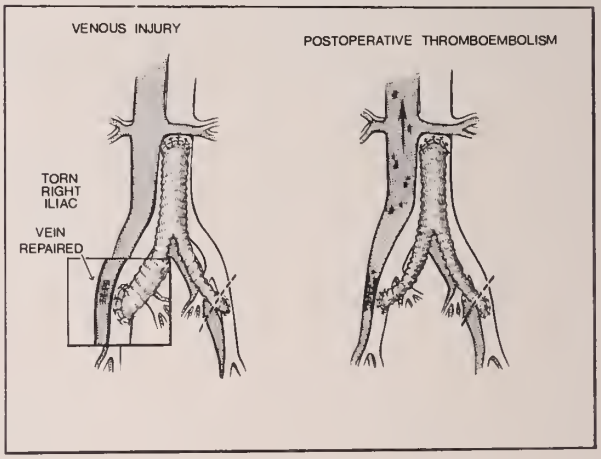


Fig. 14.

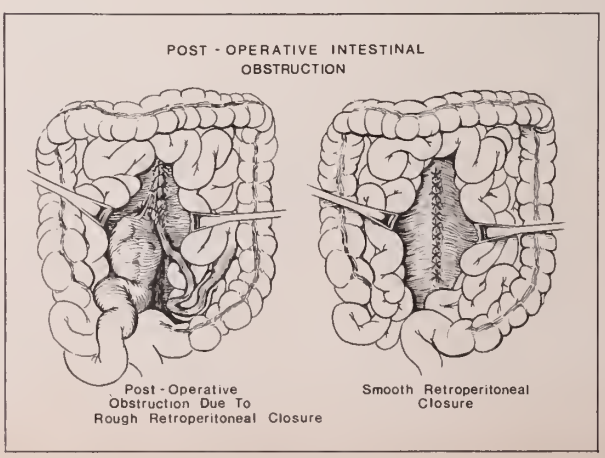


Fig. 15.

is intraoperative angiography needed. The anterior onlay piggyback graft obviates excessively deep and wide dissection and greatly reduces the danger of complications such as chylous ascites, sexual dysfunction, lower spinal cord neurological deficit, and lumbar artery and vein problems. With successful aorto-femoral graft, lumbar sympathectomy is not routinely done unless the leg outflow pattern is very poor and later femoro-popliteal surgery is under consideration, postsympathectomy neuralgia having somewhat dampened enthusiasm for this procedure.

To get good inflow above the occlusive disease process, the graft should be inserted into the abdominal aorta just below the renal arteries (*Fig. 8*), with appropriate localized aortic cleanout when needed. Complete division of the upper abdominal infrarenal aorta adds to the dissection and, in spite of theoretical flow advantages, is unnecessary.

The graft outflow must be below the worst of the occlusive disease bilaterally (*Fig. 9*). Thus, the aorto-femoral approach with its two groin incisions is preferable to the lesser complete transabdominal aorto-iliac procedure. Additionally, the lower ends of the graft are more accessible for any later surgery if needed.

If the superficial femoral artery is occluded, the profunda femoral artery must accept the outflow or be endarterectomized or grafted (*Fig. 10*). Superficial femoral arterial occlusion rarely needs concomitant femoro-popliteal vein bypass graft, although this procedure may subsequently be needed.

The exact tension of the bypass graft is difficult to determine, but it is necessary to avoid that gross excessive laxness with attendant kinking which will result in diminished flow (*Fig. 11*).

Since injury to the inferior mesenteric vein with consequent thrombosis may compromise bowel viability, extremely careful retraction is of paramount importance (*Fig. 12*).

Injury to a patent inferior mesenteric artery (*Fig. 13*) may lead to vascular difficulties, especially if good collateral circulation is lacking.

With the anterior piggyback bypass graft, injury to the venous system has recently been considerably less frequent; but if major venous injury does occur (*Fig. 14*) and repair is necessary, then postoperative thromboembolism becomes a real threat. Prophylactic venous interruption or anticoagulation may in fact actually present greater problems than their relative therapeutic value.

The retroperitoneal closure should be as neat as possible (*Fig. 15*) to avoid later bowel obstruction. It may be noted in this connection that a cushion of tissue between the graft and the bowel is helpful in decreasing the danger of aortoenteric fistula.

The previous high incidence of renal failure problems associated with major vascular surgery has been reduced by preventive measures, beginning with preoperative hydration and continuing with operative use of appropriate osmotic or other diuretics. Low output renal failure, or, less commonly, high output (*Fig.*

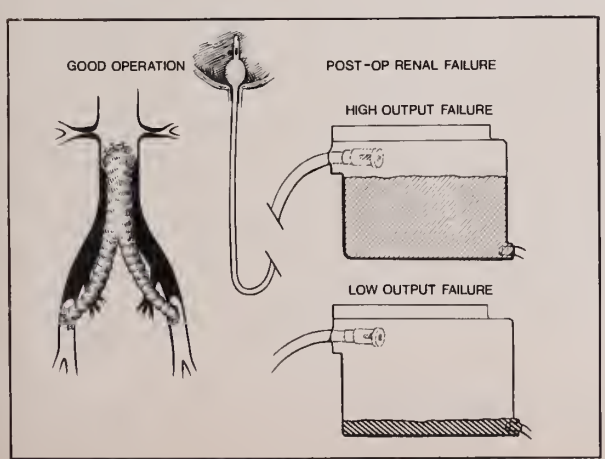


Fig. 16.

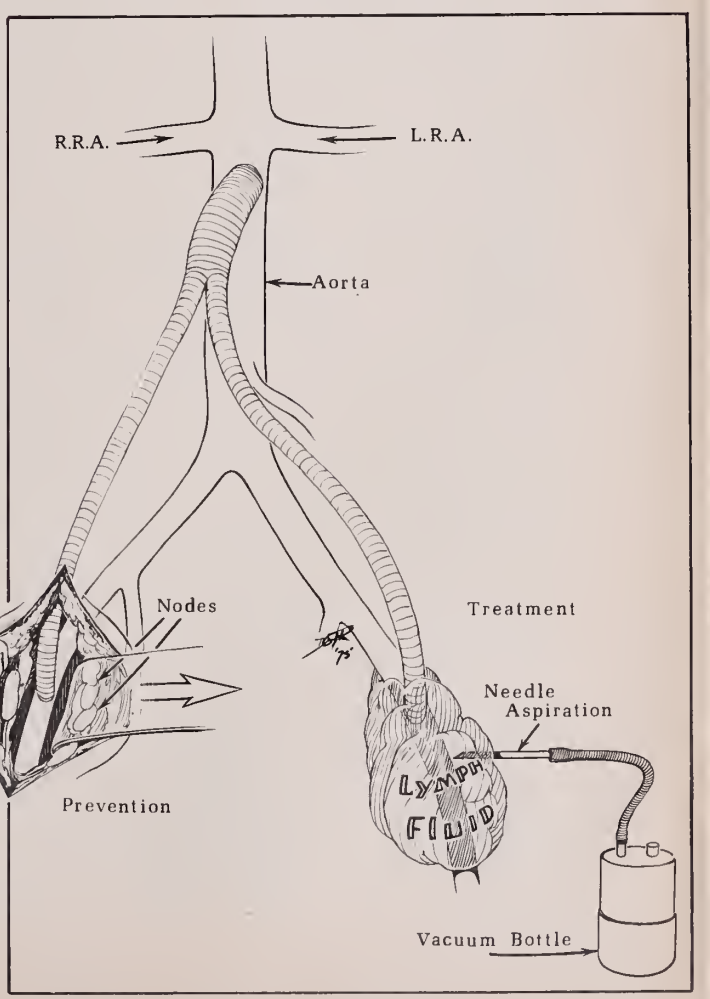


Fig. 17.

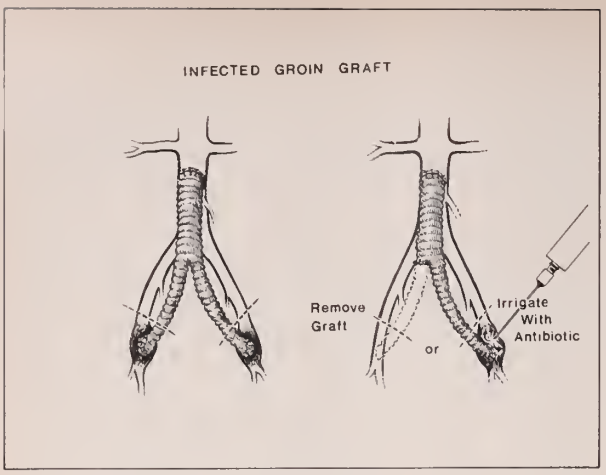


Fig. 18.

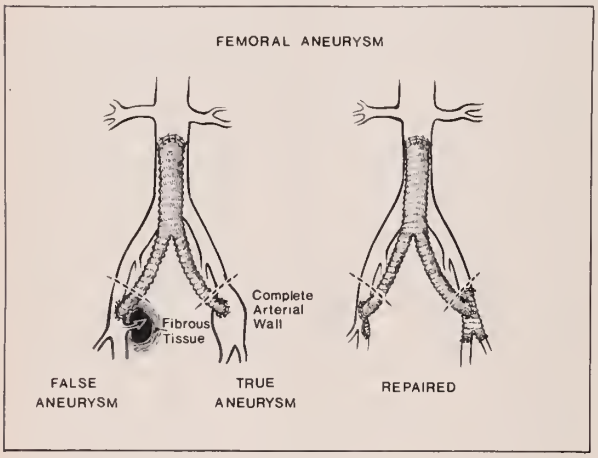


Fig. 19.

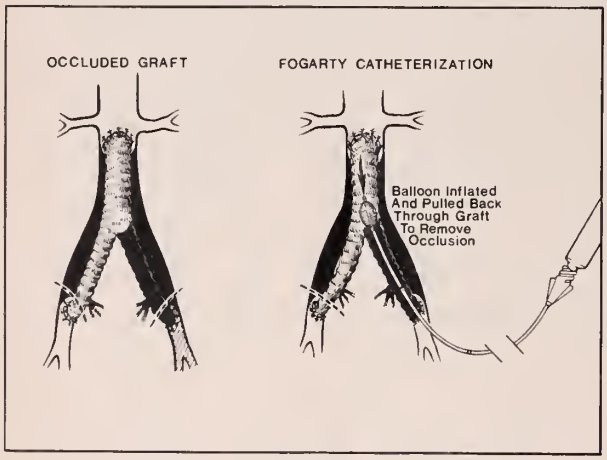


Fig. 20.

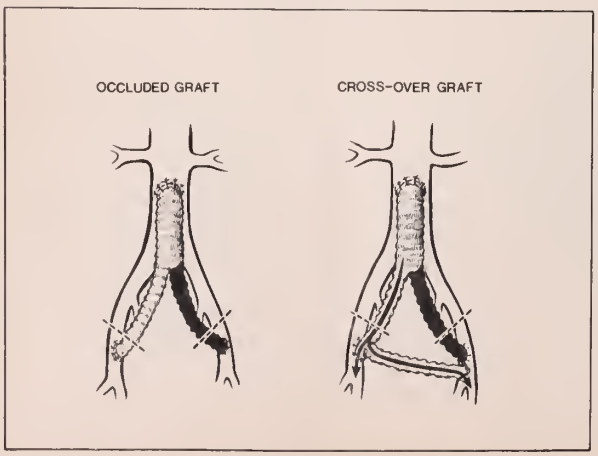


Fig. 21.

16), occurs at times, of course, despite all precautions and technically satisfactory surgery.

Even with careful groin nodal retraction (*Fig. 17*), lymphorrhea will occasionally develop in the femoral wound. This can be treated by serial aspirations or by hemovac catheter.

One of the later, most dreaded complications is infection of the cloth prosthesis, which most often occurs in the groin (*Fig. 18*). Ideally the graft should be removed, but sometimes a very aggressive antibiotic irrigation will effect a cure. Groin wound revision with sartorius muscle flap only has been reported to be successful.

Should a true aneurysm of the femoral artery occur as a late complication (*Fig. 19*), resection with venous or prosthetic graft replacement is required. More typically, the graft anastomotic area develops a false aneurysm which may require full replacement, although occasionally it can be patch grafted.

If postoperative graft occlusion (*Fig. 20*) is promptly diagnosed, Fogarty balloon catheterization may restore patency.

If the occlusion persists, a later abdominal approach can be avoided by crossover extraperitoneal femoral grafting (*Fig. 21*). Once in a while, an axillary-to-femoral graft may be more appropriate.

Summary

The surgical selection and treatment of aorto-iliac atherosclerotic disease patients has progressed beyond the stage of trial and error, having reached a plateau characterized by successful standardization. Piggyback aorto-bilateral common femoral cloth prosthetic bifurcation grafting is usually the best procedure. Meticulously performed, it offers a low complication rate. When the now less frequent, but inevitable, complications do occur, aggressive treatment is usually successful.

The discipline of vascular surgery will undoubtedly make further advances in the future. In the meantime, by the utilization of the total experiences of the past, a solid foundation has been built for present practice and for future growth.

(*References on request.*)

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The Interpretation of Routine CSF Tests

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This report will help in determining the precise significance of spinal fluid abnormalities.

THE clinician is often confronted with a laboratory report which he is not sure how to interpret, and this is certainly true of tests done on cerebrospinal fluid (CSF). One reason is that our knowledge of CSF changes are still in a rather primitive state, despite the fact that lumbar punctures have been done for a number of decades. On the other hand, it is often apparent that there is an incomplete understanding of what we do know about the CSF. The purpose of this paper is to give a brief description of some of the common tests done and what changes from normal mean. (See Table.)

Blood in the CSF: Probably the most frequently encountered problem is whether blood in the CSF represents cerebral bleeding or a traumatic tap.

One of the best tests, and the one used most commonly, is to do a cell count in the first tube and another in a subsequent tube, usually the third. This should be done even if the fluid looks grossly clear, since about 500 cells must be present before the fluid becomes hazy.[1,2] A significant drop in the RBC count of the fluid would indicate a traumatic tap. One should also observe the fluid as it comes out of the needle, since a traumatic tap often shows nonhomogeneous mixing in the drop.

In addition, a very bloody traumatic tap (greater than 200,000 RBC/mm^1) will clot on standing, which will not occur with subarachnoid bleeding.

The next step, if the fluid is bloody or colored, should be to spin down the fluid and determine the color of the *supernatant.* One often hears the remark that the fluid was xanthochromic yet the fluid was not spun down. Xanthochromia refers to a yellow color in the supernatant of spun down fluid and should not be used in reference to unspun CSF. The supernatant of a traumatic tap should be clear and colorless. On the other hand, true subarachnoid blood will begin to hemolyze in 1-2 hours[3] and will release oxyhemoglobin. This tints the supernatant an orange-red. Within 24 hours the hemoglobin begins to change to bilirubin, which tints the supernatant yellow. This may persist from a few days to weeks depending on the severity of the bleed. Its presence is taken to indicate CNS bleeding,

Test	Normal Value
Appearance	Clear and Colorless
Cell Count	Less than 5 cells (all monocytes)
Protein	Up to about 50 mg/dl *
Gamma Globulin and/or Ig G	About 10% of total Protein **

* Actual value depending on individual lab
** Actual value depending on lab and particular method used.

but one should remember that marked elevations of CSF protein (> 150 mg/dl) will also tint the fluid yellow.[3] This is because CSF protein is primarily prealbumin and albumin derived from serum. Since bilirubin is bound to albumin normally in serum, this pigment is carried with the protein as it passes into the CSF. In addition, if the serum bilirubin in very high (> 7 mg/dl), some of the unconjugated pigment may diffuse into the CSF.[3]

Protein Content: As noted above, the CSF protein is derived from serum, though the fractions are present in different proportions. The total protein content should be less than 50 mg/dl. Bleeding into the subarachnoid space

Submitted 6-10-75.

also causes a leak of serum protein into the CSF. A useful rule of thumb is that 1000 RBC is associated with a rise in CSF protein of 1 mg/dl; however, an increase is a nonspecific indication of CNS disease. One can get clues as to the etiology. In meningitis, very high levels are seen in tuberculosis and moderate elevations in bacterial infections, while viral diseases give only minimal elevations. Very high levels are also seen in such diverse disorders as Guillain-Barre syndrome, acoustic neuroma, and spinal block. In multiple sclerosis, values above 100 mg/dl are rarely seen.

Gamma Globulin: Normally this fraction of CSF protein is derived from the serum, but since only 10% of the CSF protein and 20% of the serum is gamma globulin, any breakdown in the blood brain barrier will increase the percentage. If the serum gamma globulin is markedly increased, more will get into the CSF even with a normal barrier, thereby raising the percentage, e.g., cirrhosis, multiple myeloma, lupus erythematosis. Because of this origin in serum, the absolute value of gamma globulin in the CSF may be misleading, since a high total protein value may have a high absolute amount of gamma globulin, yet the percentage is normal, and it is the percentage that has the diagnostic value.

Under certain circumstances, however, the brain itself can become an immune competent organ,[4] the classic examples being CNS lues and multiple sclerosis. In the latter disease, the gamma globulin is elevated in the CSF but normal in serum.[4] We see, though, that this test is not specific for this disease. In addition it has been found to be elevated in only 80% of cases *at some time* in the course of the illness. The level is *not* related to the clinical stage of the disease.[5]

The same statements hold true if IgG is measured instead of gamma globulin.

CSF Sugar Content: Like the CSF protein, the CSF sugar (glucose) is also derived from the serum. It enters the CSF by transport process, which follows saturation kinetics, but at the same time it is dependent on serum levels. This means that the glucose level is a reflection of the serum level up to a certain point (about 300 mg/dl). After that the transport system is working maximally.[6]

Normally the CSF glucose is ½ to ⅔ of the serum level. At high serum levels one runs into problems as just noted. The CSF content above 300 mg/dl will depend on a number of factors, e.g., how long the blood sugar has been elevated, how fast the brain is using it up, the integrity of the blood brain barrier. For these reasons, if the blood sugar is raised because of iatrogenic reasons (i.e., glucose infusion), it is a good idea either to discontinue the infusion or change it to saline one to two hours prior to the spinal tap.

Low CSF glucose levels are caused by a number of diseases. Infections are the best known, with depressed levels rarely being seen with viral infections, mild to severe reductions in bacterial infections, and extreme, often unrecordable levels in TBC and some fungal infections. Other causes include subarachnoid hemorrhage, CNS sarcoidosis, and vasculitis and tumor, if they are close to the subarachnoid space. A low CSF sugar may also be only a reflection of hypoglycemia. One should keep in mind that there is a lag period for glucose to enter the CSF; a patient could have a hypoglycemia attack but have a normal blood sugar by the time the physician sees him, whereas if the attack has occurred in the past 45 minutes or so, the CSF sugar may still be low.

Cellular Content: The cell count of the CSF should be 5/mm^1 or less with all the cells being lymphocytes or monocytes. Occasionally one may see ependymal cells, but polymorphonuclear cells should not be found. Unfortunately cell typing is often done on wet preparations, and this may give false results. To be sure of the cell type a stained smear should be made.

With bleeding from any cause, peripheral white cells may enter the CSF. With a normal peripheral white count, this amounts to 1-2 PMN/1000 RBC. After blood has been in the subarachnoid space for any period of time, it may elicit an inflammatory response, which

makes a cell count invalid for diagnostic purposes.

Increased cell counts can give a clue to the etiology of the disease. A high PMN count is usually seen with bacterial infections. Vasculitidies, demyelinating disease, subarachnoid blood, and, occasionally, mass lesions may give an increased PMN count but usually no more than 50-100/mm[1].

Viral diseases, TBC, and fungal diseases also give raised cell count, but these are usually mononuclear cells. One should keep in mind, though, that early in the disease the response may be predominantly polymorphonuclear.

Two points to keep in mind with infections is that very early in the disease, especially with pneumococcus, the CSF may be teeming with bacteria, but the cell response may be nil. Secondly, with partial treatment of bacterial meningitis, the cell type becomes mononuclear. If the initial LP is done at this point, the physician may not be sure if the infection is a bacterial or a viral meningitis. While it lies outside the usual tests done in a general hospital, some authors have noted an elevated CSF LDH in bacterial meningitis, but not viral.

We see from the above that the information obtained from routine examination of the CSF is quite limited in some respects but may be extremely useful in the diagnosis of some common neurologic disorders. It is hoped that as time goes on some of the experimental studies such as enzymes, lipids, trace metals, and metabolites may lead to more sophisticated diagnosis and treatments, as they have done with serum.

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Medical College of Virginia
Richmond, Virginia 23298

CHAMPUS: "Some doctors' payments may be somewhat lower. . . ."

The Department of Defense has directed the CHAMPUS program to change its method of payment for physicians' services in line with Medicare regulations. CHAMPUS (Civilian Health and Medical Program for the Uniformed Services) covers dependents of active duty military personnel as well as retired military personnel and their dependents.

The first change is in the calculating of payments. From now until July 1, 1976, payment wil be based on 1974 charges. Beginning July 1, 1976, and extending through June 30, 1977, charges will be based on 1975 claims data. This method conforms to the CHAMPUS fiscal year.

A second change requires that payment may not exceed the 75th percentile of the 1974 charges. Until January 1, 1976, payments were based on the 90th percentile of current charges. The new regulations will mean that some doctor's payments may be somewhat lower than those paid for similar services prior to January 1.

The same changes apply to CHAMPVA (Civilian Health and Medical Program of the Veterans Administration), which provides benefits for dependents of totally disabled veterans, or surviving dependents of veterans who have died from service-connected disability.

Blue Shield of Virginia, Richmond, administers the medical benefits for both programs, except for a portion of northern Virginia, which is served by the Blue Shield Plan headquartered in Washington, D.C.

Advice to Authors

Manuscripts

Manuscripts are welcomed for consideration on any topic relevant to the medical disciplines, with the understanding that they are contributed exclusively to the *Virginia Medical Monthly* and have not been submitted simultaneously elsewhere. Address manuscripts to the Editor, 4205 Dover Road, Richmond VA 23221. Enclose a covering letter identifying the person (by address and telephone number) responsible for negotiations concerning the article.

Once accepted for publication, the manuscript becomes the permanent property of the *Virginia Medical Monthly;* subsequent publication elsewhere will be authorized at the joint discretion of the Editor and the author.

The author is responsible for the accuracy of his statements and references. The article is subject to editorial changes designed to clarify meaning, enhance literary quality, and suit the exigencies of space and style.

Manuscripts should be *original* typed copy, not carbons or photostats, on bond paper, with *all material double spaced* (text, references, and legends) and ample margins on each side. A complete copy of all elements, including figures, must also be submitted for the use of reviewing editors. In addition, the author is charged with the retention of at least one copy of the manuscript and its figures, as insurance against loss.

The Editor will give preference to short articles that speak incisively to a well defined subject.

The manuscript should include the title of the article. It should be short, specific, and amenable to indexing.

A short abstract should be included, giving a factual (not descriptive) summary of the work. This should be typed in double space on a separate page.

The manuscript should include the full name(s) of the author(s) with identifying degrees, affiliations, and complete addresses, as well as institutional and other credits.

The generic as well as the trade names of pharmaceutical products must be given. All units of measure must be in the metric system.

Illustrations

Authors are encouraged to have illustrations professionally drawn or photographed. Acceptable are India ink drawings on white paper, or glossy black and white photographs, preferably 5 x 7. Each figure must be identified on the back with the name of the author, the figure number, and a clear indicator of the top of the figure. Each illustration must be referred to in the text. Legends should be typewritten in *double space* on a separate page, with numbers corresponding to those on the figures. Photographs of patients should have identifying features masked or be accompanied by copies of signed permission for reproduction. Symbols or arrows used in figures should be professionally drawn or put on with Prestape and should be clearly identified and explained in the legend. The Editor reserves the right to limit the print cost of illustrations to $15 per article; special arrangements must be made for illustrations exceeding that sum.

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References should be numbered consecutively as they appear in the text and listed in that numerical order. Select references carefully, so that they do not become unwieldy. Given below is the style to follow in referring to a journal article, a book, a chapter in an edited book, and a presentation at a meeting.

1. Santiago PJ, Santini R Jr, Perez E, et al: Congenital isolated defect of folic acid absorption. J Pediatr 82:450-455, 1973
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4. Jones JJ, Smith AW: Thyroiditis in the adolescent. Presented at the 49th annual meeting of the Endocrine Society, Chicago, June 20-22, 1967

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Tables should be typed on separate sheets in single space and a classic typeface so that they may be photographed as they are for publication, thus avoiding the excessive costs of tabular typesetting. Number with Arabic numerals and provide a legend for each table, typed separately. Excessive tabular data is discouraged, and, in general, data presented in tables should not be duplicated in the text or figures.

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Authors will receive galley proofs prior to publication. These are for the correction of typographical errors only, and *text changes may not be made.* (Should the author anticipate the need for updating the article close to publication date, the Editor should be so advised when the manuscript is submitted.) The galley proofs must be returned to the Editor within 48 hours from receipt.

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An order form for reprints is attached to the galley proofs.



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- Found useful in the management of vertigo* associated with diseases affecting the vestibular system.
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BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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(meclizine HCl) 25 mg. Tablets
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Serum K^+ and BUN should be checked periodically. (See Warnings Section.)



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

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Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

SK&F Co., Carolina, P.R. 00630
Subsidiary of SmithKline Corporation

Case Report . . . .

Massive Spinal Cord Infarction due to Vascular Invasion by Reticulum Cell Sarcoma

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Although it is unusual to find such extensive cord necrosis as was seen in the present case, there are a number of ways in which the spinal cord can be damaged in the lymphoproliferative disorders. The most important cause of such damage with lymphoma is an epidural tumor mass which may cause cord compression and necrosis[1]. Yet levels above and below the point of stricture are largely spared, with the exception of tract degeneration. Akin to this mechanism is the rarer pathological fracture of a vertebra involved with lymphoma which results in cord compression[2]. Infiltration of the spinal cord parenchyma by lymphoma cells in sufficient numbers to produce injury is also rare[3,4].

Less well substantiated causes of cord damage associated with lymphoma have been degenerative changes variously ascribed to remote mechanisms such as a hypothetical circulating toxin, immune factors, or unknown causes[4]. In these cases a picture like that of subacute combined degeneration has been described[5,6]. However, the existence of severe posterior column disease as a paraneoplastic syndrome has been questioned[7]. Segmental cord necrosis as a remote effect has also been reported[8]. Other central nervous system lesions associated with lymphoproliferative disorders include progressive multifocal leukoencephalopathy, which has its highest incidence with lymphomas and which occasionally involves the cord[9]; radiation necrosis of the spinal cord following therapy for lymphomas[10,11]; and syringomyelia, which has been associated with Hodgkin's disease[12].

Finally, vascular compromise of the spinal cord beyond that which may accompany cord compression or radiation has been suggested as a mechanism of destruction in the lymphoproliferative disorders. The primary mechanism advanced has been compression of nutrient vessels as they pass through the intervertebral foramina[13], either by tumor infiltrating the nerve roots or growing through the foramina, or by collapse of involved vertebral bone into the foramina[14]. It is the purpose of this communication to report a case of reticulum cell sarcoma with massive cord necrosis in which still other vascular mechanisms may have been principally responsible for the myelomalacia.

Case Report

A 51-year-old woman was in good health until she was admitted to a hospital with the complaint of severe pain in her right lower extremity. The right lower leg was cold but there were full and equal pulses in all extremities, both proximally and distally. One observer felt that Homan's sign was positive. The remainder of her examination was normal. A diagnosis of thrombophlebitis was made and the patient was anticoagulated with heparin and later with coumadin. On the 13th hospital day her left leg was cool, discolored, and swollen. On the 14th hospital day she was noted to be paraplegic, with flaccid lower extremities. During this time her prothrombin time never exceeded 2½ times that of the control value. On the 15th hospital day she was transferred to the Medical College of Virginia.

On arrival her vital signs were normal. She had bilateral leg swelling with good distal pulses. She was oriented to person only. Her cranial nerves were normal. She had a sensory level at the umbilicus. Both lower extremities were flaccid, and she was incontinent of urine and feces.

The following laboratory data were obtained: Hemoglobin 10.0 gm%, WBC 11,000 per cubic mm with normal differential, blood sugar 105 mg%, BUN 50 mg%, Na^+ 118 meq/l, Cl^+ 84 meq/l, K^+ 5.1 meq/l, CO_2 27 meq/l. Her prothrombin time was 33 seconds with a control of 11 seconds. Her PTT was 54 seconds with a control of 40 seconds. Platelets were 36,000 per

From the Department of Neurology and the Divisions of Academic Pathology and Neuropathology of the Department of Pathology, Medical College of Virginia, Richmond.

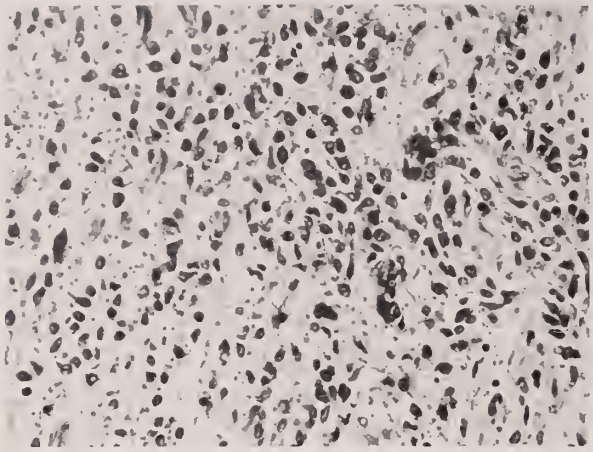


Fig. 1. Representative field of reticulum cell sarcoma demonstrating pleomorphic nature of cells, vesicular nuclei and prominent nucleoli. Reticulin fibers stain lightly and course among the tumor cells.



Fig. 2. Cross section of spinal cord illustrating massive necrosis. Note focal islands of relatively preserved myelinated nerve fibers and central grey matter.

cubic mm. Serum STS and FTA were nonreactive. Sed rate was 51 mm per hour. LE prep, ANA titer, and latex flocculation were negative. Lumbar punctures were performed on the first and third day after transfer. Similar results were obtained in both spinal taps. The opening pressure was 170 mm CSF. A Queckenstedt test was normal. The fluid showed 1180 red cells per cubic mm and 36 white cells per cubic mm with 30 lymphocytes, 3 polymorphs and 3 monocytes. The supernatant was clear. CSF sugar was 60 mg% with a blood sugar of 105 mg%. Protein was 58 mg%. Bacterial and acid fast cultures were negative. Initial chest xray was normal. Thoracic spine films showed only mildly degenerative changes at the 9th and 10th thoracic levels. An echoencephalogram was midline. An EEG showed diffuse slowing in the theta range. A brain scan was nondiagnostic.

On the 18th hospital day the patient developed shock and oliguria with progressive renal failure. In addition, pneumonia and bilateral gangrene of the lower extremities became apparent. On the 21st hospital day an arteriogram of the aorta and both femoral arteries showed generalized narrowing of all branches of the abdominal aorta. The vessel walls were smooth. Bilateral above the knee amputations were performed. Despite this and continued antishock measures, she died on the 36th hospital day. She had shown no evidence of regaining spinal cord function.

Pathological Findings

General Autopsy: Significant postmortem findings included: 1) a large continuous thrombus involving all major veins of the lower extremities and extending to 2 cm above the junction of the femoral veins into the inferior vena cava and 2) widespread tumor. Both adrenals were replaced by tumor and the kidneys were somewhat large and swollen. Petechial hemorrhages were seen over their surfaces, and there were streaks of pale tissue in the renal parenchyma. The liver and spleen were enlarged but showed no gross evidence of tumor infiltration. Microscopically, malignant reticulum cells (*Fig. 1*) replaced the adrenals and diffusely invaded the thyroid, lung, mediastinal and retroperitoneal nodes, liver, spleen, kidneys, bone marrow, uterus, bladder, and lumina of veins of the pelvis and lower extremities. A silver stain demonstrated numerous reticulin fibers coursing among the tumor cells. Organizing thrombus was also noted in the pelvic and leg veins.

Neuropathologic findings: There was no epidural or subdural mass compressing the cord but the spinal cord was very soft and dusky gray in appearance, from the midthoracic area through the sacral segments. Cut sections of the cord revealed necrotic tissue with a discolored small area of hemorrhagic infarction in the sacral segments. Microscopically, the myelomalacia was characterized by lack of cellular detail and pallor of staining which involved the entire cross sectional area of the spinal cord below the mid-thoracic level (*Fig. 2*). In some areas numerous gitter cells were encountered, and there was beginning cavitation. Only in sacral segments was the necrotic tissue suffused with erythrocytes, and tumor cells were not present at any site in the cord parenchyma. Reticulum cell sarcoma was encountered, however, in the leptomeninges and there was an invasion of leptomeningeal vessels, predominantly veins but also arteries (*Fig. 3*). In some instances

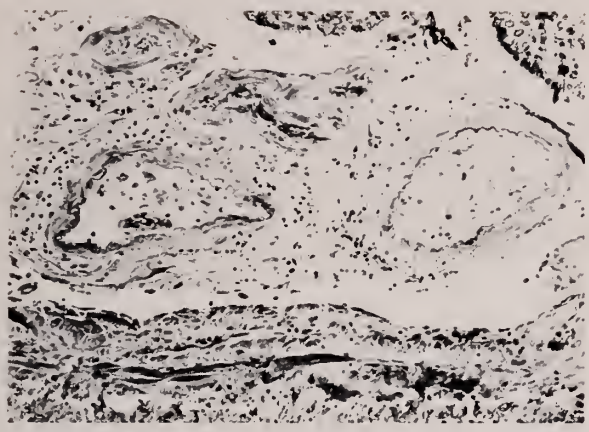


Fig. 3. Verhoeff van Gieson elastic stain demonstrating malignant reticulum cells within the lumina of small spinal arteries.

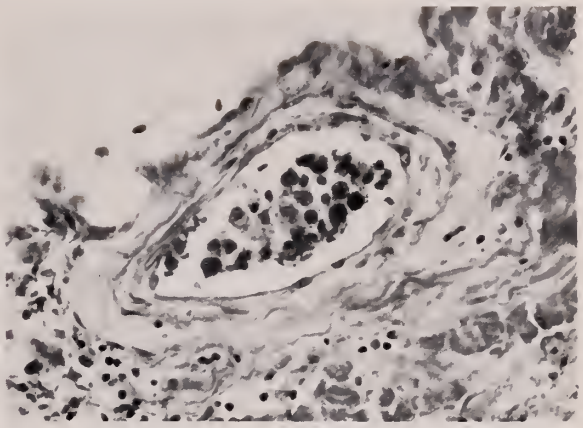


Fig. 4. A mass of reticulum cells within the lumen of a small subarachnoid vein.

numerous tumor cells were seen in the lumina (*Fig. 4*) and in other instances the lumina were totally obstructed by tumor cells.

In adjacent vascular segments, thrombosis, organization, and recanalization of vessels was noted. In many segments the new lumen was only 5-10% of the caliber of the original lumen (*Fig. 5*). The vessel walls contained varying numbers of mature lymphocytes and plasma cells. Such cells were occasionally encountered in association with malignant reticulum cells in the vessel walls. Reticulum cell sarcoma was also seen infiltrating some of the nerve roots and ganglia (*Fig. 6*) as well as the lumina and walls of vessels supplying these structures. Permission to examine the brain was not granted.

Discussion

It may be seen from the pathologic examination that there was invasion of the lumina of subarachnoid vessels and vessels of nerve roots by reticulum cell sarcoma with thrombosis of these vessels. Tumor also infiltrated the nerve roots themselves. There was total necrosis of the spinal cord below the mid-thoracic level. Yet no epidural tumor, vertebral body lesions, or spinal cord invasion was found.

Vascular compromise of the spinal cord by lymphoma has been discussed as a mode of production of spinal cord necrosis[4]. The principal mechanism suggested has been compression of nutrient blood vessels[15,4]. If compression of vessels occurs in the intervertebral foramina, then to produce the massive necrosis that we have here, one would expect to see extensive involvement of serial nerve roots bilaterally. In the present case, although there is invasion of nerve roots (*Fig. 6*) and of the

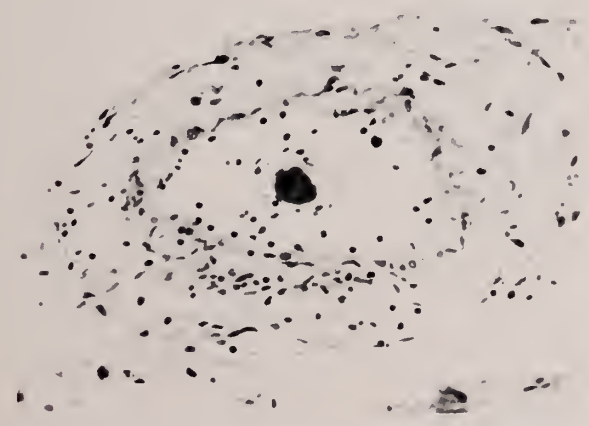


Fig. 5. Recanalized vein with markedly narrowed lumen and chronic inflammatory cells within the vessel wall.

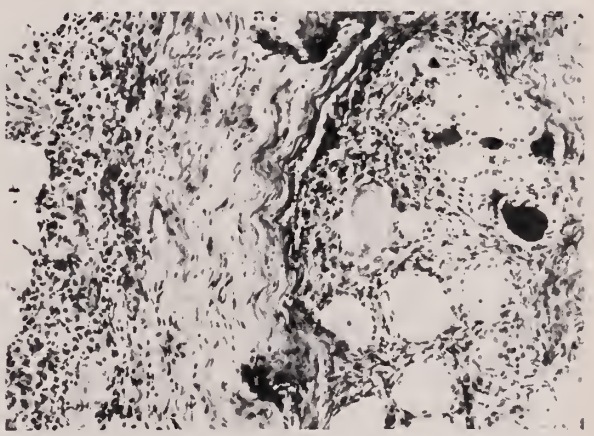


Fig. 6. Dorsal root (left) and ganglion (right) demonstrating infiltration by malignant reticulum cells.

vessels of these roots, tumor is absent in some roots while it is present only to a modest or moderate degree in others. We attribute the massive necrosis in this case primarily to invasion of malignant reticulum cells into the lumina of small arteries (*Fig. 3*) and, to a greater extent, veins (*Fig. 4*) supplying the cord within the spinal subarachnoid space. This resulted in widespread thrombosis of these vessels.

This is an unusual presentation for reticulum cell sarcoma, because the endothelial lining is not usually transgressed by these tumor cells to a degree which is microscopically conspicuous. On the other hand, involvement of the outer vessel coats, the Virchow-Robin spaces, and the adjacent brain parenchyma has been universally observed[16,17,4]. Thus invasion by malignant reticuloendothelial cells is generally a centrifugal process which proceeds from the perivascular space and vessel wall into the parenchyma, rather than a centripetal process which proceeds into the lumen. Though some authors have suggested that lymphomas may cause cord necrosis by invading vessels[4], this does not appear to be a well-documented mechanism[17]. Indeed, Griffen[18] reported 21 cases with meningeal lymphoma, of which 15 were reticulum cell sarcoma, and no cases of malignant thromboses were seen, despite the frequent occurrence of the previously mentioned vascular and perivascular changes. In the present case, blockade of cord vessels by tumor resulted in thrombosis and subsequent cord infarction. A discussion of our case at the International Symposium on Malignant Lymphomas of the Nervous System, Vienna, Austria, August 29-31, 1974, revealed that the presentation of reticulum cell sarcoma here reported is extremely rare.

Another finding of note was the presence of chronic inflammatory cells in the walls of vessels near the tumor (*Fig. 5*). These cells were not considered to be neoplastic, since they obviously consisted of mature lymphocytes and plasma cells. The association of such cells with reticulum cell sarcoma-microglioma in relationship to CNS vessels has been commented upon by a number of workers[16,19,13] and may be analogous to the reactive lymphocytic infiltrations which are often seen around the proliferated vessels in glioblastoma multiforme. Here, however, they were most prominent in segments of thrombosed vessels, predominantly small veins, not directly involved by tumor (*Fig. 5*). In some instances the endothelium was markedly thickened, and the lumina were reduced to 5% of the normal size. In other areas several small lumina were seen. The media and adventitia were also thickened. This picture seems most consistent with organization and recanalization of thrombosed vessels, and therefore the inflammatory cells may be largely reacting to the thrombosis rather than to the neoplasm itself.

In addition to involvement of cord vessels, systemic veins and vessels within other organs were likewise invaded by reticulum cell sarcoma, and were thrombosed. It is certainly possible that occlusion of the lower vena cava and of the iliac veins would contribute to the poor drainage of the lower cord and result in spasm and decreased flow on the arterial side, as well as subsequently decreased flow to the spinal cord. Indeed, narrowing of major branches of the abdominal aorta was noted on the arteriogram performed late in the hospital course. Thus involvement of abdominal and pelvic veins may have also contributed to the cord necrosis. We feel that the major mechanism was direct invasion of the lumina of veins, and, to a lesser extent, of arteries by reticulum cell sarcoma, which resulted in thrombosis. Hemodynamic changes may have acted synergistically with the small vessel invasion to produce such massive destruction. Finally, nerve root invasion may have contributed to the damage by causing altered blood flow through the intervertebral foramina.

The present case illustrates vascular mechanisms which should be considered among the many mechanisms through which the spinal cord may be damaged in the lymphoproliferative disorders. This group of illnesses should be considered in the differential diagnosis of spinal cord dysfunction even in a patient without

prior history of lymphoma, and without partial or complete subarachnoid block.

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Problems of the Child with Mental Retardation

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Richmond, Virginia

A MAJORITY of the children with retarded development do not look different from normally developing children, especially during the preschool age. A few children, however, are easily identified, such as the child with Down's Syndrome (Mongoloid).

In terms of growth and development, all children follow the same progression. It is the *rate* of development which varies. If a child develops at half the normal rate, he achieves the same milestones, but at a slower rate; for example, the 1-year developmental milestones will be reached at 2 years of age. This explains the slow speech development in a child whose IQ is 50, or developmental rate half the normal rate. To enable us to understand him, we speak of his mental age or developmental level instead of his chronological age. The ultimate potential is determined by cognitive ability. Sixteen years can be considered an arbitrary end point of cognitive development; hence a child with a developmental rate of half normal would, as an adult, have a mental age of 8 (plus or minus 1 to 2 years depending on individual variation).

The rate of height and weight gain is frequently normal even though the rate of development is slowed. This results in problems, i.e., public acceptance of a 6-year-old child with 2-year-old behavior (developmental rate 1/3 of normal). Many of the problems of this child and his family are related to the mental age of the child.

Not statistically retarded, but a slow learner in school, is the child with a developmental rate of 70-90%. Since as a rule he is not eligible for special education, he is persistently at the bottom of his class and may repeat a grade every one or two years, or get social promotions which keep him abreast of his chronological age group but hopelessly behind in his achievement and ability to catch up. He is denied the opportunity of the successes of which he is capable. The result of this is a ruined self-image and a suspicious, short-tempered adult, who feels with justification that the world is laughing at him and always ready to take advantage of him.

With academics geared to his abilities and support in learning to deal with the realities of the work world, the slow learner can and does become a useful and self-supporting citizen as an adult.

The educable child's developmental rate is 52-68% of normal. The upper educable child can become a self-supporting adult or partially so, but always needs a supporting adult to turn to for decisions in times of social and economic stress. The lower educable child is capable of repetitious jobs with supervision, such as are found in sheltered workshops. At home, he needs daily supervision.

The trainable child whose developmental rate is 36-51% of normal can be very helpful in the household or in doing simple supervised farm chores. High trainables can work in sheltered workshops. These people attain little or no academic achievement; all need supervision throughout life.

The severely retarded group whose developmental rate is 20-35% of normal, and the profoundly retarded group whose developmental rate is less than 20% of normal, are never capable of self-care and present enormous daily problems to the family, especially when they reach adolescent and adult size. Imagine a 2-year-old in an adult body.

However, children in all of these categories have needs and feelings like yours and mine. They need love and acceptance in the roles in

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Presented at the Child Psychiatry Forum, Richmond, May 24, 1974.

which they can perform. They know when they are rejected and react by hostility or deviant behavior. They want to become as independent as they are capable of becoming, and they welcome constructive training in this direction. They have a basic need to experience achievement and success and to feel necessary and useful. They learn best by imitation and will imitate whatever behavior they see, good or bad. Hence the home pattern becomes very apparent in the actions of these children at school or in the neighborhood.

THE major source of the child's problems is the same as ours, *frustration*, but for different reasons, i.e., not being able to communicate due to inadequately developed speech; not being able to play a game or write due to gross or fine motor incoordination; not being able to read due to a perceptual handicap; not understanding directions due to a language deficit, short attention span, or intellectual deficit; not being able to go out with other teenagers; not being able to be one of the gang; not being able to get a driver's license at 16 because he can't pass the written test, etc. The problems arise as the person with less than a normal developmental level for his age and size tries to fit into the world.

How do these children adapt? They must first adapt to their own limitations in motor, speech, perceptual, cognitive, and emotional development; in addition, they may have brain damage.

The infant grapples with his own problems of locomotion and speech. He may see his world differently because of strabismus, or defective visual perception. He may hear abnormally because of deafness or auditory perception problems. He may have a fear of falling or being tossed into the air due to abnormal space perception, or he may not feel pain or taste as we do due to abnormal sensory perception.

The child may "trip over his own feet"; he may sustain chin and forehead bruises and cuts requiring sutures. He may not be able to catch a ball. Fine motor incoordination affects buttoning, zipping, using crayons and scissors. Programs of games and recreational activities at home and at school aid the child to achieve more control over his muscles.

Speech development is frequently slower than performance abilities. This is seen on the Wechsler Intelligence Scale for Children psychological test in the wide variance between verbal and performance abilities. One must determine the developmental levels of both the expressive and receptive speech.

Deficient receptive speech may be due to defective hearing, auditory perception handicap, or lack of language. Defective hearing can require medical treatment and/or a hearing aid. Auditory perception handicap can be helped by insisting on eye contact and having the child repeat the directions he is given. In school, visual cues are necessary. Language therapy is beneficial for both expressive and receptive language when due to lack of language. Articulation therapy is frequently needed even when language therapy is not.

Visual perceptual handicaps occur in the child with retarded development just as they do in normal children with learning disabilities. Proper teaching techniques are just as necessary as they are for the normal child with learning disabilities.

Cognitive growth or intellectual growth will determine the child's ultimate mental age or ability to deal with abtsract matters. The better the cognitive growth, the more independent and self-sustaining the child can become if—and this is just as important—the emotional growth proceeds at the same rate.

Emotional growth may be affected or arrested at any stage due to a child's inability to cope with his environment. Early emotional growth may suffer because of the parents' disturbed behavior reactions to a diagnosis of retardation at birth. Parents may withdraw from a severely retarded infant.

The child may have medical problems, such as numerous upper respiratory infections, resulting in frequent contact with doctors, nurses, needles and medicines, as a result of repeated otitis, he may be partially deaf. He may need surgery for strabismus,

orthopedic corrective procedures, congenital heart, hernia, or other problems. Long-term illnesses may result in his mother and/or family becoming overprotective or rejecting.

The moderately to profoundly retarded child is more apt to have brain damage. He may exhibit motor driven hyperactivity, poor impulse control, stubbornness, and temper tantrums to the extent that his behavior may seem psychotic. This, however, is not psychosis.

Hyperactivity can be either organic or situational. An organic hyperactivity is motor driven and persists despite an environmental change. A situational hyperactivity occurs in a grossly disturbing environment, which may be school, home, or neighborhood. The child becomes frustrated, has frequent failures, or begins to act out. Sometimes the diagnosis is difficult, but situational hyperactivity usually disappears in a one-to-one situation in which the environment is pleasant and comfortable for the child and he can begin to realize some successes.

The child is strongly affected by his immediate environment, parents, siblings, and extended family. If parents are over-protective or over-indulgent, the child cannot achieve independence. The child of rejecting and/or disturbed parents may respond by withdrawal and passive resistance or by deviant behavior. Home relationships will form the basis of all future relationships with other people.

Children with slow development face many frustrations and failures. Much of their frequent failures and subsequent punishments are due to lack of judgment and ability to anticipate. They are very sensitive to failure and punishment, as they lack the ability to understand cause and effect.

EARLY learned behavior persists in slowly developing children, as they have a great deal of difficulty changing their ideas. If the child is taught in the early years to greet relatives and friends with a kiss and a hug, he will not understand why, as a teenager or an adult, he must shake hands. As an adult he may be functioning at 5 or 6 years. Therefore, he must be taught with an eye to the future. How do we want him to act at 20? We must begin with his first learning experiences in a manner that will result in appropriate responses as an adult.

A child may be ridiculed because of his looks, speech, or actions, which hurts any loving parent as well as the child. This can be a neighborhood problem. The parental response will determine the child's ability to handle such situations in the future.

Development of maladaptive behavior is usually related to frustrations caused by inappropriate demands upon the child or adult. Consistent discipline decreases deviant behavior. The parent may well be a large part of the child's problem. If parents and siblings accept the child as he is, understand his growth in all spheres as related to his developmental level, they can help him cope more easily with his environment. It takes two simultaneous failures to defeat a child, such as failure to meet his needs at home and school, leaving him abjectly alone with no one on his side.

School presents another hurdle, especially for the undiagnosed child who has been viewed as normal at home. Suddenly he is required to do tasks appropriate to his chronological age, but not appropriate to his developmental age. This leads to academic and social failures, damaged self-image, and behavior problems. The typical cycle is school failure, angry parental response, behavior problems at school, behavior problems at home, and frustration on the part of the child, parents, and school. Quick recognition of his developmental level and the assignment of appropriate tasks will alleviate many of his frustrations and allow him to learn at his own rate. Each child has his strengths; building on these diminishes frustrations for the child and teacher. Acceptance, unlimited patience, and love on the part of the teacher, combined with structuring his learning environment in a way best suited to the child's strengths, is a winning combination. Open lines of communication between parent and teacher are a must. A united approach on the part of parents and teacher reinforces what the child learns at school.

The child must also cope with his peers in school, children in the neighborhood who are

by no means accepting and patient, and the world of adults who, not knowing him, demand behavior appropriate to his chronological age. Frustrations? By the hundreds.

As a teenager, the typical tensions and questionings of adolescence exist. Much attention and guidance from adults is necessary. Answers need to be given appropriate to the teenager's mental age. To keep them busy, teenagers need programs of social activities with peer groups, and physical exercise appropriate to motor abilities and developmental levels as well as interests. The mildly retarded child is very aware of his deficiencies, and the upper educable group may react emotionally to a label of "mental retardation".

Once school is over, the high educable group slips into the adult population and is lost to statistics. The low educable and trainable groups have no world of peers and no job except for those who are able to work in a sheltered workshop or live in a community which provides a daily activities program. Far too few of these programs exist. The less fortunate lose the skills they learned in school and stay at home with time on their hands and opportunity to get into trouble.

AS for parental problems, a child with retardation will accentuate whatever individual existing problems there already are, such as insecurity, anxiety, or retardation of the parent. If the parent is retarded, he sees no slowness in the child and is incapable of helping the child solve problems. If the newborn period is critical, parental fears may cause over-protection. If the infant has colic, parental guilt may result in an over-solicitous or a rejecting parent. With a slowly developing child, a parent must be more acutely aware of the child's readiness for tasks and give to him as he needs it, without hampering his striving to become independent, or leaving him alone and unable to cope. Some parents deny any slowness or find many excuses for it. Some overcompensate and over-protect the child. Parents may reject a diagnosis of retarded development and shop around for a diagnosis more acceptable to their needs. If they accept the diagnosis, they may ignore the siblings and concentrate on the retarded child. For example: "If I have a child with retarded development, I'm going to be the best doggone parent of a slowly developing child in the community. His brothers and sisters can look out for themlselves!"

Whatever the reactions are, both parents need to be involved, and it is more necessary than ever to be in agreement on how to handle the child and present a united approach. This child cannot possibly understand two separate but simultaneous modes of parental action.

If the parents can accept the child as he is and be comfortable with him, then it is easier for neighbors, teachers and other friends to be comfortable with him also, and for the child to be comfortable with himself.

The parents need a source of guidance, some authority to answer their questions about the length of different stages of growth, how to handle the retarded teenager, what to anticipate as an adult, what to do when they, the parents, die. They need help in handling their own fears and anxieties. They must have all the available information to make a decision; then they need support to make their own decisions. Parents need some one to confirm their own worth and the child's worth. Finally, they need information concerning placement as well as support in making the decision if this is the only alternative.

A rural environment is easier for the person with retardation as it is a simpler pattern of life. The age of the parents may be the factor precipitating expulsion from a family as a parent reaches his physical limitations. And finally, the family as a unit needs a sustained and sustaining source of help.

As can be seen, the problems of the child and his family are related to helping him fit into his environment in a way most profitable to himself and to society.

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(References on request.)

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To find out more about our comprehensive program contact the Co-Medical Directors, Dietrich W. Heyder, M.D., F.A.P.A., or Fathy A. Abdou, M.D., F.A.P.A., Human Resource Institute of Norfolk, Human Resources Building, 100 Kingsley Lane, Norfolk, Virginia 23505. Phone (804) 489-1072.

Problems of the Cerebral Palsy Child and his Family

GAYLE G. ARNOLD, M.D.
Richmond, Virginia

The term, "cerebral palsy," is herein used to include any cerebral dysfunctions manifested by gait disturbance, poor condition, visual perceptual problems, auditory perceptual problems, with seizure, learning and speech disorders. Any or all of these may coexist.

EARLY parental anxiety may date to the moment of birth, when the newborn may have problems such as asphyxia, respiratory distress, prematurity, or any combination of these, causing the obstetrician-pediatrician team to have anxiety as to any "after-effects" in the child. Such newborns are now called high-risk newborns, and it will be of great interest to me over the next decade or two to see the hopefully positive effect of more far-sighted and heroic management of the newborn with difficulties in intensive care units, such as the one the Medical College of Virginia has pioneered to minimize "after-effects" on the baby. Unfortunately, however, these "after-effects" may not always be apparent until school age, since they may involve cognitive achievements and the like.

Parental anxiety over a high-risk newborn is greatly reinforced when the later islands of development are slowed. The child may not sit, stand, walk, or talk "on time." Medical help is sought, and very frequently frustration results from this, since the physician may either hesitate to commit himself at such an early age, or he may "over-diagnose" on very meager grounds, causing a panic reaction in the parents. They then begin to shop around, getting other, sometimes conflicting, opinions, and much confusion results. Many times the necessary differentiation between mental retardation and physical inability is a difficult one for parents to understand.

Dr. Arnold *is Pediatric Director of the Richmond Cerebral Palsy Center.*

Presented at the Child Psychiatry Spring Forum, Richmond, May 24, 1974.

The staff of a treatment center may create problems for the parents. Occasionally they give a poor prognosis which is unwarranted. More frequently, however, they create optimism in the parents because of an unjustifiably euphoric prognosis. There are several reasons for this over-optimism. First, staff members are sympathetic to the parents and do not wish to make them face unpleasant realities. Second, certain members of the staff may lack experience and have not followed the progress of such children for sufficient time to learn the natural course of the "disease" or condition. In most cases, however, the staff and family become involved in a personal struggle against the "disease", and in this struggle the staff member may lose objectivity. Fortunately, this problem is minimized by "staffing," in which the child's history, course of treatment, and results are discussed in a round table situation, where less personal bias is forthcoming and less personal involvement is allowed to color the picture.

A feeling of anger is also a common reaction in parents. It may originally be directed at Fate. "Why did this have to happen to me and my child?" Later, the parents may direct this free-floating anger toward the physician who delivered the baby, or to another physician caring for the baby because he seems unable to "cure" the "disease." At times, a certain amount of anger is directed toward the child, and this causes fright in the parents because of their ambivalent feelings.

In one study carried out by questionnaires to parents of cerebral palsy* children, 62% thought their child was sent to them as a punishment. Such a feeling is especially pronounced if the pregnancy happened to be unwanted or unplanned, and guilt is accentuated even more if the mother had tried, early in pregnancy, to terminate it by long walks, hot baths, drugs, etc. Many mothers with a medical condition which has been suggested to be

related to cerebral dysfunction in the child, such as poorly controlled diabetes, have especially marked guilt feelings and feel personally responsible for the problem. In the study mentioned, 70% thought God had given them their child as a cross to bear.

At the same time, the parents' interpersonal relationship is strained by having a child who is "different." The mother has guilt feelings because of an "imperfect" child, and the father may have some jealousy because of the extra attention and anxiety this child is causing. Infrequently, one parent may accuse the other of not loving the child, or not assuming his share of the responsibility for his care. As years go by, the gulf between the parents widens. Separation and/or divorce is statistically more common when there is a child with a severe or chronic handicap in the home. The basic parental disturbance preexists the handicapped child in the home, however.

Over-expectations and unrealistic goals for the cerebral palsy child are common, when both parents and child are studied. Because of a relatively good score on IQ testing, executive positions may be thought attainable, when actually the patient is unable to write legibly, or has a severe dysarthria, either of which would seem to militate against executive functioning.

One outlet for parental anxiety may be neglect. By subconsciously refusing to accept the handicap the child may be isolated from the family activities and thus hidden from view of parents and community alike. A similar correlary to this is the refusal to go to a professionally directed treatment program, since an "if we ignore it, maybe it will go away" attitude presents.

In addition to neglect, handicapped children are statistically higher on the list of abused children, as high as 2:1 in some surveys, showing that the resentment of their problem and the problems it causes can be taken out in a very physical way on the child. We have had to resort to court intervention on at least two occasions when cerebral palsy children were severely abused by resentful parents.

OTHER groups of parents are quite the opposite in their handling of a cerebral palsy child. The combination of early guilt feelings and later anxiety leads to over-protection of the child. This is normal to a degree, but carried to extremes it causes obvious problems in the child; he seems spoiled, immature, demanding, and is poorly motivated. He may react to such over-protection with shyness, fear, withdrawn behavior, and an unwillingness for self-assertion. We have seen intelligent parents who are unable to allow their child to try in a self-assertive situation, thus telegraphing to him their opinion that he has already failed it, without his ever making an attempt. Intellectual understanding of a handicapping situation by parents must be accompanied by emotional understanding and acceptance. The child feels the acceptance, or lack of it, and tends to project these feelings in his own self-image and acceptance of his problems. He may feel it is difficult to make friends in a sheltered environment, and, as a special school child, he may lack contacts in the neighborhood. Parents may have to push such contacts, in church groups, camp experiences, and games. With contact, he may find rejection by his peers because of his handicap, or their reluctance to be a friend to him, whereas others may be insensitive to his special needs and either ignore or ridicule him. It is not rare for the moderately involved teenager to try totally to ignore any handicap, deny its existence, and try to compete at unrealistic levels of achievement. Others in their teens who admit to their handicap become severely depressed and have been heard to say, "I'd have been better off dead." Adult cerebral palsy patients who are severely involved may also have this reaction and may be suicidal, at times successfully.

Once parents have accepted the problem of the child with cerebral palsy, they then must face the possibility of frequent hospitalizations, continuous visits to numerous physicians, special schools for long periods, relative neglect of other children in the family, and continuous financial output for necessary treatment and special equipment, such as shoes, braces, chairs, etc. Long term medication may be a great financial burden also. Patients with cerebral dysfunction may need anticonvulsive medica-

tion, especially the spastic ones, for years at a time. In addition, drugs to control the hyperkinetic impulse disorder (not so minimal as the term minimal brain damage implies) may be needed from early school age until the teens. Even more recently, an antispasticity drug, dantrolene sodium (Dantrium), shows much promise in relieving spasticity, and its long term use on a daily basis could be necessary. Any or all of these medications might be necessary in any one child. The parental problems of locating a proper facility for assistance, transportation to and from that facility, and the establishment of communication with physicians and therapists may be huge for them.

Parents must work to build the child's self-image and must distinguish early between abilities and disabilities. Normal versus abnormal behavior is a difficult problem. Many times abnormal, intolerable behavior is blamed on the cerebral dysfunction, when, in a child without cerebral dysfunction, it would be recognized as inappropriate behavior calling for disciplinary measures. We must not allow the presence of a physical handicap to color or prejudice our thinking in dealing with an emotionally disturbed child or their parents.

Another superimposed manifestation of cerebral dysfunction already mentioned may be hyperkinetic behavior, with or without learning disabilities. Parents who must deal with the frustrations of the hyperactive, distractable child with an extremely short attention span, while at the same time being assured that he has normal intelligence or is indeed bright, or perhaps bright but with a learning disability causing him to do poorly in school, certainly must be recognized. It is of much interest that these manifestations of cerebral dysfunction are responding to techniques evolved by occupational and physical therapists working with children who have an additional physical handicap, such as one with spastic quadriplegic cerebral palsy as a primary diagnosis. Much more must be learned as to the neurophysiologic and neuroanatomic bases for these manifestations of cerebral dysfunction, and it is from these studies that future lessening of the problems of the cerebral palsy patient and his family may be possible.

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Calendar of Medical Events, 1976

March

Neonatology for the Practicing Physician—Sponsored by Department of Pediatrics, MCV—Richmond—March 18.

"Challenges of Drug Therapy, 1976"—Sponsored by the American Academy of Physicians and the University of Virginia School of Medicine—Boar's Head Inn and McLeod Auditorium, Charlottesville—March 24-26.

29th Annual Stoneburner Lecture Series—Neurology for Primary Care Physicians—Sponsored by Department of Neurology, MCV—Richmond—March 25-26.

April

Pediatric Cardiology for the Practicing Physician—Sponsored by Department of Pediatrics—Pediatric Cardiology, MCV—Richmond—April 1.

International Surgical Conference—Sponsored by Department of Surgery with Department of Continuing Education, MCV—Williamsburg—April 4-11.

Recent Advances in Neurology—Sponsored by Pediatric Continuing Education Program, University of Virginia School of Medicine—McKim Conference Center, Charlottesville—April 8.

6th Annual Charles W. Thomas Lecture on Rheumatology—Medical College of Virginia, Richmond—April 13. Speaker: James B. Wyngaarden, M.D., Duke University, "The Newer Subtypes of Primary Gout."

Annual Joint Cardiac Symposium—Sponsored by the Heart Association of Northern Virginia—Arlington—April 21.

Medico Legal Workshop—Sponsored by Office of Chief Medical Examiner, MCV Department of Legal Medicine, Virginia Society for Pathology, Inc. and Virginia Academy of Family Physicians—Virginia Baptist Hospital, Lynchburg—April 22.

Pediatric Day—The Sutton Lectureship—Sponsored by Department of Pediatrics, MCV—Hyatt House, Richmond—April 22-24.

Practical Advances in Medicine—MCH 9th Annual Symposium—Sponsored by Medical Center Hospitals and Eastern Virginia Medical School—Omni International Hotel, Norfolk—April 26-27.

Swineford Allergy Conference—Sponsored by the Department of Medicine, University of Virginia, Charlottesville—April 30.

Virginia Surgical Society—Annual Meeting—The Homestead—Hot Springs—April 30-May 1.

May

The 1976 Southeast Emergency Medicine Congress—Sponsored by the Southeast Chapters of the American College of Emergency Physicians and the School of Medicine Medical College of Georgia—Atlanta—May 3-5.

Recent Advances in Endocrinology—Sponsored by American Academy of Pediatrics—McKim Conference Room, University of Virginia, Charlottesville—May 6-8.

EEG Symposium—Sponsored by Department of Neurology, MCV—Richmond—May 17-18.

Annual Spring Forum for Child Psychiatry—Sponsored by Division of Child Psychiatry, MCV, and Virginia Treatment Center for Children—Richmond—May 21.

Clinical Rheumatology for the Practicing Physician—Sponsored by the Virginia Chapter of the Arthritis Foundation, Virginia Regional Medical Program, Medical College of Virginia, University of Virginia School of Medicine, and Eastern Virginia Medical School—Bonhomme Richard Inn, Williamsburg—May 21-22.

Annual Clinical Session—The Virginia Society of Ophthalmology and Otolaryngology—Williamsburg Conference Center—May 26-29.

Editorial....

A Notification of Purpose and a Call for Help

THE doctor of today is in danger of being inundated by the tidal wave of medical journals, pamphlets, magazines, newspapers, drug flyers, and other reading matter that crests all too frequently with the arrival of the office mail. Example, the Medical College of Virginia library receives approximately 4,500 serials on a continuing basis, of which some 3,000 are directed towards the medical profession. Trying to "keep up" with *the* literature may be a bit like trying each week to read a volume the size of "Gone With The Wind". And, after attempting to assimilate some of the mass of printed material, one may, in all propriety, plagiarize Clark Gable's immortal closing line, "Frankly, I don't give a damn."

Why is such a trite and obvious observation the introduction to this first editorial in the *Virginia Medical Monthly* by your new editor? The *Virginia Medical Monthly* is certainly no Johnny-come-lately to the realm of medical publishing. Under the able guidance of distinguished editors and other dedicated individuals, it has earned and held for generations a secure position in its field. Each month it properly demands the time and attention of its 6,000 readers, more than 5,000 of whom are members of The Medical Society of Virginia. And yet, each new editor undertaking the guidance of any journal regardless of its past and present must look to the future and must examine his charge critically in terms of its purposes and goals, and how to achieve these. If a medical journal is to compete effectively for the time and attention of today's physician, it must stand the test of "What's in it for me", which requires a clearly defined raison d'etre. The *Virginia Medical Monthly* is no exception.

In my judgment, the *Virginia Medical Monthly* has four primary purposes, which are:

- To serve as the official publication of The Medical Society of Virginia and thereby to be the prime means of communication between the Society and its members, as well as between each of its members.
- To keep the doctors of Virginia abreast of major medical issues, and to promote thoughts concerning medicine, particularly in Virginia.
- To furnish a medium through which our readers can publish scientific papers, and a forum through which they can express themselves about current medical topics—philosophic, socioeconomic, scientific, or whatever.
- To function as an important source of continuing education for our readers.

Fortunately, none of these is mutually exclusive and each can be pursued in fruitful conjunction with the others. None of these can be held to justify a provincialism, or limited goals. The proceedings of The Medical Society of Virginia, matters of concern to the doctors of Virginia, and the scientific presentations should have such merit that they would have value for members of the medical profession wherever they may be. Let me expand each of these purposes.

To be the official organ of The Medical Society of Virginia—The *Virginia Medical Monthly* is owned by, financed by, and published by the more than

5,000 individuals who are members of The Medical Society of Virginia and of its component societies. Particularly in these times when it is essential that a unified group deal effectively with pressing problems, malpractice insurance to name just one, the necessity for close communication cannot be overemphasized. The considerations and actions of the leaders of our Society must be known to and understood by our members. Additionally, our members must have the opportunity to make themselves heard. Whatever else the *Virginia Medical Monthly* may accomplish, it must maintain effective communication at all levels between the members, the component societies, and The Medical Society of Virginia. It is the only device which can serve this purpose.

To keep the doctors of Virginia abreast of major medical issues—This is a broadening of the first stated purpose. As an example, here is the opportunity to consider the impact of state and federal legislation on the medical profession; to debate the medical problems of this area; to make known the challenges to the practice of medicine; to analyze the needs of our citizens that should best be met by the medical profession; to be aware of how other states are responding to and dealing with similar issues.

To be the medium through which our readers can express themselves—To put pen to paper and thus to transmit ideas, convictions, and observations is an important exercise for every doctor, hard as it may be for many, including this editor. Indeed, much of the body of medical knowledge originated at the grass roots level from the shrewd observations and the recording of these by keen practitioners. Today there continue to be many important case reports, findings, and conclusions that go unrecorded and unpublished. The writer inevitably learns far more than the reader. Publishing a scientific paper is one of the best methods of learning about any given subject. This journal should afford a forum, the vehicle by which our readers may have a participating interest in scientific and philosophic matters relating to the broad field of medicine.

To function as an important source of continuing education—This is listed in final place not because it is of lesser importance. As all of us are well aware, continuing education, with the corollaries of reexamination and recertification, is one of the hottest issues facing our profession today, and no one can question the importance of it. I sincerely hope and expect that all that is published in the *Virginia Medical Monthly* will have a useful educational value.

Two facts must be kept in mind, however. First, there are many journals whose primary goal is the dissemination of scientific knowledge. Of these, most are specialty and/or research oriented. We do not want, nor do we expect, to compete with such journals as the *Journal of Clinical Investigation*, the *American Journal of Medicine*, or *Surgery, Gynecology and Obstetrics*. Second, our journal must be concerned with all of the branches of medicine, for all disciplines are represented by our members. We cannot focus on one specialty or one area at the expense of the many others.

So, as I see it, our *Virginia Medical Monthly* is a unique journal that has a specific mission and clearly defined purposes. It has been and will be different from many other outstanding journals. But value judgments as to which journal is "better" are neither appropriate nor possible without posing the

question, "Better for what?" The *Virginia Medical Monthly*, like any other publication, must be judged by the validity of its goals and how effectively it strives to achieve them.

I hope very much that many of you will let me have your thoughts as to what the purposes of our journal should be, and what steps should be taken to achieve them. This is your journal. Its level of excellence and its value depend on you.

W. T. T.

(*This is the first part of a two-part editorial.*)

To the Editor . . . .

It was recently brought to my attention that The Medical Society of Virginia will bring to a vote the question of reexamination for relicensure. I do not believe that any usual examination can fairly test all the practicing physicians in Virginia on what they ought to know.

The Virginia graduate's first medical license is granted upon completion of medical school. At this time he is examined in the four major disciplines of obstetrics, pediatrics, medicine, and surgery. Most physicians then take specialty training in one of these areas. How can a test in all of these areas be fair to the physician limiting his practice to only one of them? I do not think that it can be!

If an examination must be drawn up, my one plea would be this, *make it a self-assessment type.* Wherein the questions are answered elsewhere in the material.

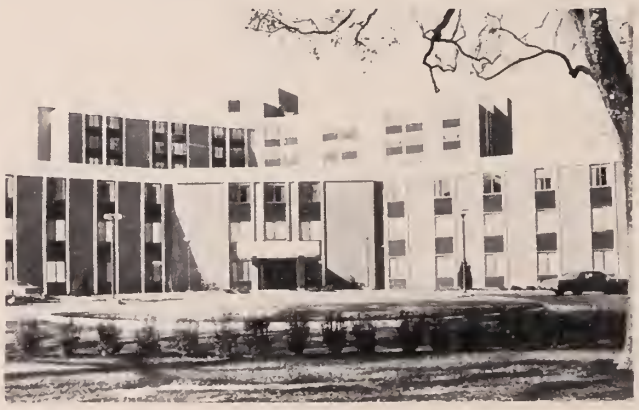
How many times have we finished a test not knowing one more fact than when we came to it? Here is an opportunity to give our physicians those facts that were important enough to be examined on. If medical education must come by examination, let's make it a *learning experience.*

David Gray Crittenden, M.D.

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Commentary . . . .

The Need for Integrity

AT THE INITIAL organizational meetings of the Central Virginia Council, the question of a mission or program for the Virginia Association of Professions was discussed. Extended conversation revealed that each profession suffers from continuing encroachments of government. However, it occurred to some of us that these are only fragments of a larger question: namely, the survival of our Republic as outlined at Williamsburg and Philadelphia by our founders. To paraphrase Benjamin Franklin: If we do not hang together relative to the larger problem, our various professions will hang separately.

Many of our people have become so obsessed with Watergate and the current economic situation that there is a tendency to forget the greatness of America. Familiarity breeds contempt, and sometimes it is useful to obtain the views of an individual who is not so close to the problem: Let me cite for you what a foreign physician says about our country.

Dr. John Racy was born in England in 1932 of Lebanese parents. Raised in Lebanon, where he attended the elementary and preparatory sections of the International College in Beirut, he enrolled in the American University of Beirut in 1948 and entered its medical school in 1951. After receiving his BA degree in 1952 and his MD degree in 1956, both with distinction, he took up psychiatric residency training at the University of Rochester School of Medicine and Dentistry in Rochester, N.Y., from 1956-1959. During this time, he was a Rockefeller fellow. After further training in child psychiatry and liaison (psychosomatic medicine), he returned in 1960 to the American University of Beirut with the intention of establishing an academic department of psychiatry. During a 6-year stay, he organized courses, consulted on patients, taught students in various health fields, and conducted investigation relevant to psychiatry in the Arab East. He immigrated to the U.S. in 1966 and accepted an academic position at Rochester.

The following is an excerpt from an article by Dr. Racy entitled "A Foreign Graduate with U.S. Training Reimmigrates to the United States," which appeared in the September 1974 issue of *The Archives of Surgery:*

"Why do foreign physicians remain in this country? Without statistical data to corroborate my impressions, I believe that some or all of the following operate in determining each physician's decision to leave his mother country behind him:

1. Economic considerations. With few exceptions, foreign physicians find they can earn much more here than in their native land. This is so despite the worldwide shortage of physicians and their high socioeconomic status. The shortage is skewed however, and to a certain extent unreal in urban centers and capitals, where there may indeed be an overabundance of physicians.

"2. Freedom of opportunity. Few countries provide so many choices for the physician in terms of specialty, type of work, geographic location, and freedom of movement.

"3. Style of life. Despite the many criticisms of the American style of life that come mostly from native Americans, this society represents the fulfillment of living toward which many millions in developing countries aspire. Since foreign physicians are often in the forefront of their countries' Westernization, they are in a position to appreciate what the West has to offer. Many speak of their great admiration for fine public schools, clean uncontaminated food and water, good roads, reasonably civil civil servants, ease of processing official documents (such as passports, licenses, deeds of purchase, credit), a rich assortment of consumer products, and so forth.

". . . . there is a tendency to forget the greatness of America."

"4. Disillusionment or distress in the native country. This probably is the most subtle and least understood factor. After all, it does require a certain amount of discomfort to undertake the burdens of migration. Distress can stem from a vague but persistent irritation with the mother country's style of life (slow pace, corrupt government bureaucracy, stifling educational policy,

Amplification of remarks made before the Virginia Association of Professions Annual Meeting, Fredericksburg, 21 September 1974.

noise, poor sanitation, binding social obligations, and so on). It can also stem from specific deficiencies (in career opportunity, monetary reward or support, advancement, and, above all, recognition) or injuries (family strife, conflict with the government, adverse discrimination on the basis of race, religion, or sex, public or private humiliation, and so on)." [1]

I might add that what Dr. Racy has said with regard to medicine applies to all professions and all Americans, whatever their station in life might be. His statement reveals the great attraction of America to millions in other lands. Unfortunately, many of us take our good fortune too much for granted.

". . . . we suffer greatly from over-communication and lack of solitude."

Now, we are at a turning point in our history. Time does not permit a detailed account of how we arrived at our present state. However, we all know the turbulence that has existed for more than a decade, with protest marches, unrest and violence in the colleges, increased crime, militant demands of minorities, and the turmoil of the last National Democratic Party Convention.

All of these extralegal activities and preachments of false ideals have created a revolutionary political culture that has permeated the communications media, our schools, and all aspects of our daily life. This revolutionary political culture is particularly evident in academia, and, to a considerable extent, it prepared the hostile environment that led to the disgrace of Watergate and resignation of our highest public official and symbol of national unity.

To paraphrase Boorstin and to add additional thoughts of the writer: If we are to survive as a Republic, we must abandon our prevalent belief in the superior wisdom of the ignorant; we must give up the generally accepted tolerance of disrespect for law and the voguish reverence for youth; we must take a closer look at the concept of tenure in our schools, which in too many instances has been used to teach subversion of American Democracy under the guise of academic freedom; and we must cease looking to the ill-informed and impractical as arbiters of our schools and culture.

Our advanced technological society puts severe strains on all of us, and we suffer greatly from over-communication and lack of solitude. In fact, comedian Bob Hope remarked recently that today's world is so stressful that it takes nerves of steel just to be a psychoneurotic. Sometimes, I am fearful that we are not up to the daily task of a healthy upright life, and I wonder what we might do if faced with a serious confrontation by a foreign power. However, I find solace in our history and cause for guarded optimism relative to future challenges, both foreign and domestic.

To conclude, our present crisis is, in a very basic sense, political in nature. It involves constitutional power, the political virtues of our public officials, and the civic virtues of us all. Lest we forget, I urge you to take the time to reacquaint yourself with the Preamble of the United States Constitution, for it is there that we find the very basis of our republic.

The great movement of our history has been to bring people together, and, if we would preserve our hard-won Republic, then we professionals must conduct our daily lives in a way that gives meaning to the concept of duty, honor, and country, and lead the way back to integrity in government and interpersonal relationships.

". . . . our present crisis is, in a very basic sense, political in nature."

Eugene Reyes Perez, M.D.

Reference

1. Racy J: A foreign graduate with U.S. training reimmigrates to the United States. Arch Surg 9: 366, 1974

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Exclusively For Children and Adolescents-- A new, completely modern 66-bed hospital is now open for patient referrals

■ Work has recently been completed on this new hospital, specifically designed for the treatment of the emotionally disturbed. In addition to the hospital itself, the Center is moving ahead with construction of a gymnasium and swimming pool to provide its patients with the very best of private institutional facilities in the Mid-Atlantic Region.

■ Four full-time child psychiatrists and a staff of experienced psychologists, psychiatric nurses, psychiatric social workers, therapists and other specialists offer a wide range of treatment modalities. A fully-accredited school program features small classes structured to meet the needs of the individual.

Brochure on Request



Richmond Times-Dispatch

Sunday, July 15, 1973

New Hospital Planned

Plans to build a 66 bed hospital building and to renovate existing facilities have been announced by the Commonwealth Psychiatric Center here.

Work on the new hospital on the center's grounds at 3001 Fifth Ave. is scheduled to start within a few weeks. Completion of the project is expected in late 1974.

Dr. William M. Lordi, director of the center, said the cost of the project, including development costs, renovation site work and the actual construction will be more than $1 million.

Lordi said work on renovating the present facilities has already started.

He said three buildings—the Lor Berg Family Guidance Clinic, Janus Hall and Jacob Silverburg Academy—are to be improved. The renovation will include interior improvements throughout all three, modernization of kitchen and dining rooms and installation of a gym, a workshop and an activity room.

The new hospital building will be a two-story structure with 33 semi-private rooms, six juniors, seven offices for doctors, an examining room, two main nursing stations and a complete dining room.

Plans for the expansion have been approved by the Capital Area Comprehensive Health Planning Council. Lordi said the council is the official health planning authority in the Richmond area.

The expansion is being made to meet a shortage of child and adolescent mental health programs in the Richmond area, Lordi said.

Currently the center has an 18 bed hospital facility.

Lordi said adolescent admissions to mental health centers have almost doubled in the United States in the last 10 years.

Recent surveys have indicated that 10 per cent of all school aged children are in need of psychiatric help, Lordi said. He said half of these were serious enough to require inhospital care.

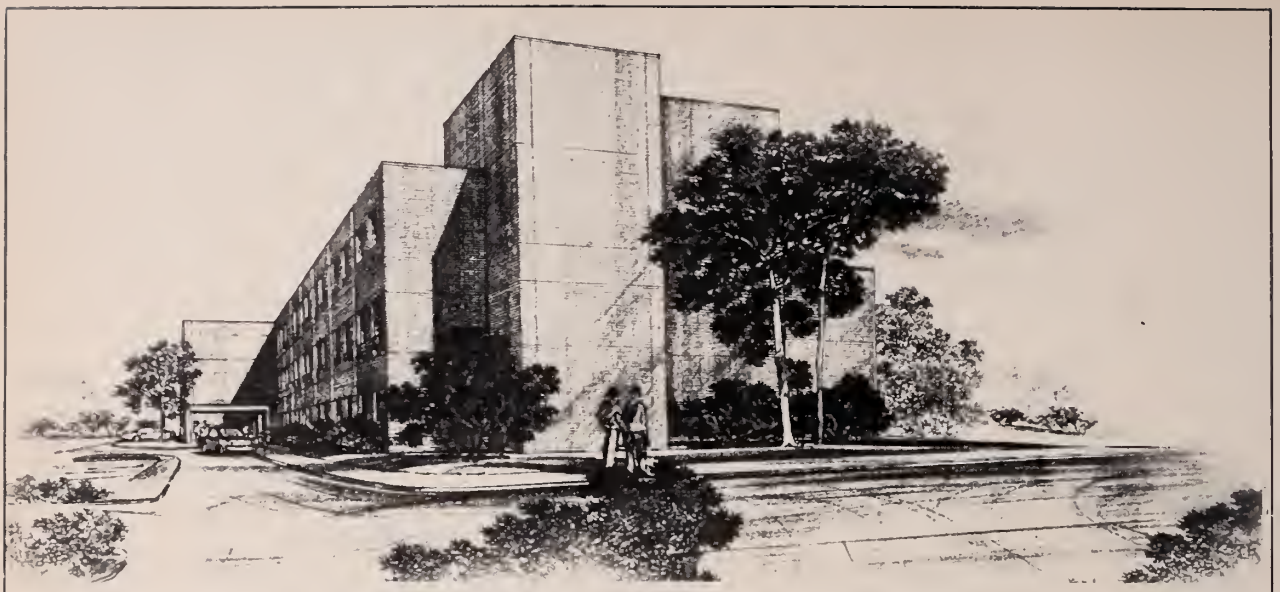
The Commonwealth Psychiatric Center is the only one in Virginia devoted almost entirely to child and adolescent mental problems. The center primarily handles children aged 5 to 18, but also cares for adults as outpatients.

Architects for the new hospital building are Lockman Associates of Washington.

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Obituary . . . .

Alvin Frederick Coburn, M.D.
Charlottesville

Alvin F. Coburn, M.D., physician, educator, author, and scholar, died at his Charlottesville home on December 29, 1975. He was 76 years old. At the time of his death, Dr. Coburn was Senior Research Scholar at the University of Virginia and Professor Emeritus of Microbiology at New York Medical College, these two honors culminating distinguished achievements as a rheumatologist.

A native of Charleston, South Carolina, Dr. Coburn received his M.D. degree from Johns Hopkins University, where he also served his surgical internship. Successively, he then interned in medicine at Presbyterian Hospital, was resident physician at Columbia-Presbyterian Medical Center, and held fellowships of medicine at Columbia University, all in New York. During these years he became widely known for his discoveries in the cause and prevention of rheumatic fever. In 1931 his book, *The Factor of Infection in the Rheumatic State*, was published by Williams & Wilkins.

Subsequently, Dr. Coburn held many professional and consulting appointments in the New York area, and served also as Director of the Pelham Home for Children and as a Fellow of the Rockefeller Institute. During World War II, he was in charge of the streptococcal control program at bases throughout the U.S. for the Navy Department's Communicable Disease Section. Overseas duty took him to North Africa, where he conceived and organized the Naval Medical Research Unit No. 3 (NaMRU3), still active in Cairo.

After the war, he returned to rheumatic fever research as founder and Director of Northwestern University's Rheumatic Fever Research Institute. More recently, he was successively Director of Clinical Research Laboratories for Bard Pharmaceutical Development; a general practitioner in Tobago, West Indies; and Assistant Dean and Professor at New York Medical College.

Only last year his autobiographical account of his fifty years in medicine, *Commitment Total*, was published by Walker & Co. He also co-authored *The Epidemiology of Hemolytic Streptococcus* (Williams & Wilkins, 1949) and *Splenin A in Rheumatic Fever* (Charles C. Thomas, 1955).

Among many professional honors, Dr. Coburn was a Fellow of the American Association for the Advancement of Science and was awarded, in 1957, the James D. Bruce Memorial Award by the American College of Physicians. He was a member of the Medical Society of Virginia.

He is survived by his wife and their six children.

Margueritte J. Kersey, M.D.
Peterstown, West Virginia

From W. W. Kersey, Jr., M.D., comes word of the death of his wife, Dr. Margueritte J. Kersey, ophthalmologist and internist, who died of metastatic breast cancer in Peterstown, West Virginia, on August 8, 1975, at the age of 59. A South Carolinian by birth, Dr. Kersey graduated from the Medical College of Virginia, Richmond, in 1944. She was a member of the Medical Societies of Virginia and West Virginia.

In partnership with her husband, Dr. Kersey practiced general medicine in Bartley, West Virginia, during the late 40's and early 50's. When they moved to Peterstown, she established her own office practice in ophthalmology. For many years she was National Medical Examiner for the Ladies Society of the Brotherhood of Enginemen and Firemen of the Southern Railway. In addition to her husband, she is survived by a son and daughter.

Ralph A. Stata, M.D.
Virginia Beach, Virginia

Dr. Ralph A. Stata, a member of The Medical Society of Virginia since 1939, died in Virginia Beach on August 26, 1975, at 61 years of age. He was a graduate of the Tennessee University School of Medicine, Memphis, and took residencies at Norfolk General and Leigh Memorial Hospitals. His specialties were general practice and ob/gyn.

Charles Hanson Peterson, M.D.
Hollins

Charles Hanson Peterson, M.D., died at his home, Route 1, Hollins, Virginia, on Monday, November 10, 1975. He was born January 26, 1904, in Monterey, Highland County, Virginia. He graduated from the School of Medicine of the University of Virginia in 1926 and served as intern, resident in medicine, and resident in radiology, all at the University of Virginia Hospital.

In 1930, he moved to Roanoke to become radiologist to Jefferson Hospital and remained in that position until Jefferson Hospital merged with Community Hospital of Roanoke Valley in 1967. Doctor Peterson was radiologist to the Shenandoah Hospital from 1934 to 1970 and was on

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the staff of the Roanoke Memorial Hospitals and the Lewis-Gale Hospital. He was Consulting Radiologist at the Veterans Administration Hospital, Salem, Virginia.

In 1931, he opened an office for the practice of radiology in the Medical Arts Building, Roanoke, was joined there in 1938 by Dr. Allen Barker and in 1941 by Dr. C. D. Smith to form the firm of Peterson, Barker and Smith. In 1966, this group became Radiology Associates of Roanoke, Dr. Peterson remaining as senior member until his retirement in 1970.

Dr. Peterson was a member and Deacon of the First Presbyterian Church, Roanoke, and a member of Roanoke Rotary Club. He was a member of the Roanoke Academy of Medicine and president of that organization in 1948. He was a member of the Virginia Radiological Society (Virginia Chapter, American College of Radiology) and president of that organization in 1948. He was a member of the Southern Medical Association Society and was elected Chairman of the Section on Radiology of that society in 1941. In addition, he was a member of the Medical Society of Virginia, The Southwestern Virginia Medical, the AMA, the American Roentgen Ray Society, the American Radium Society, and the Radiological Society of North America. He was a Fellow of the American College of Radiology.

Dr. Peterson was the first formally trained radiologist to practice in Southwest Virginia and became one of the first radiologists to be certified by the American Board of Radiology when that Board was organized in 1934.

Dr. Peterson was married to Cornelia Burnett Brooking, a graduate of the School of Nursing of the University of Virginia. They had three children, Charles H. Peterson, Jr., M.D., Roanoke, William B. Peterson, Martinsville, and Nancy Stuart Peterson, Hollins, and four grandchildren.

As founder of a large radiology group, Dr. Peterson insisted on selection of associates to maintain high quality radiologic services. Once an associate was chosen, Dr. Peterson never interfered with his professional work, though he was always available for professional consultations, to discuss public relations, and to discuss personal matters; in these relationships he had the happy faculty of expressing a solution to the matter in a droll and humorous way.

Dr. Peterson chose his possessions and friends carefully and believed he lived in the best of all worlds: in his opinion, he had the best family, the best house, the best professional associates and the best friends, and those of us who were fortunate enough to know him and be associated with him are inclined to agree. He lived a full and happy life, accomplishing many things without fanfare. His presence is, and will be, sorely missed.

Calvin T. Burton, M.D.
Hugh H. Trout, Jr., M.D.
Charles D. Smith, M.D.
Roanoke Academy of Medicine

(*Continued from page 194, "Major Hepatic Trauma," by Michael Swank, M.D.*)

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John T. T. Hundley, M.D.
Lynchburg

The Lynchburg Academy of Medicine, the City of Lynchburg, and The Medical Society of Virginia suffered an irreplaceable loss with the illness and death on December 15, 1975, of Dr. John T. T. Hundley.

Dr. Hundley was born at Dunnsville, Virginia, in 1898. His father was best remembered as long-time president of Lynchburg College. Dr. Hundley received his academic degree from Lynchburg College and his medical degree from the University of Maryland's School of Medicine in 1923. After an internship in Bridgeport, Connecticut, and a private general practice in West Virginia, he moved to Lynchburg in 1931. He lived and served in Lynchburg from 1931 to his retirement in 1969, except for his army service in World War II. Dr. Hundley's army service from 1942-1944 was in the United States, North Africa, and Italy.

Dr. Hundley practiced internal medicine in Lynchburg from 1931 to 1957—private practice plus serving for years as attending physician of the medical clinics of the Lynchburg Department of Health, plus participating in the active staff work of the Lynchburg General Hospital. He also served on the active staff of the Virginia Baptist and Marshall Lodge Memorial Hospitals.

During this time he was quite active and gave service to the community by serving on the board of Piedmont Hospital Association (later merged with Blue Cross-Blue Shield) and also on the board of the Lynchburg Guidance Center. He was on the original organizing committee of both of these organizations, and his good judgment, his study to be informed, and his courage to take an unpopular stand when he saw it as right, made him a most valuable member.

In organized medicine he served the Lynchburg Academy of Medicine as secretary for several years on two separate occasions and also as its president in 1941-1942. He served in the House of Delegates and the Council of The Medical Society of Virginia, later being elected president of The Medical Society of Virginia in 1952. As president, he was most energetic and met problems with his customary good judgment. We feel he was equal to anyone who ever held this high office. Later he served for a number of terms as speaker of the House of Delegates of The Medical Society of Virginia.

In 1957, at the request of the administration of our city, Dr. Hundley accepted the post as Director of Public Health. This forced his giving up his private practice. He served in this public office from 1957 to 1969 with the same interest and executive ability he showed in his other endeavors. Reaching the age of mandatory retirement in 1969, he continued his devotion to medicine by serving as physician for the juvenile detention center until ill health forced him to give this up. During this final phase of his active life he wrote the history of the Lynchburg Academy of Medicine.

In his final illness, Dr. Hundley showed great fortitude and bore his discomfort most admirably.

We all feel a real loss with the final illness and death of this fine man, fine citizen and worthy physician. "He had a full life and served well!"

It is moved that this resolution be adopted by the Lynchburg Academy of Medicine and be spread on our minutes and a copy be sent to the family of Dr. Hundley and to the Virginia Medical Monthly.

Edwin A. Harper, M.D.
J. E. Haynsworth, M.D.
George B. Craddock, M.D., *Chairman*

The Tri-County Medical Society has these new officers: Richard N. Baylor, M.D., Suffolk, president; Benjamin Goodman, M.D., Franklin, vice-president; J. Floyd Clingenpeel, Franklin, secretary-treasurer.



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We Salute . . . .

A big study of family practice in Virginia, authored by Virginians, was the focus of the entire February issue of the national *Journal of Family Practice*. The writers who received this unusual recognition: Dr. David W. Marsland, assistant director of the MCV family practice center in Newport News; Dr. Fitzhugh Mayo, chairman of the MCV family practice department, Richmond; and Dr. Maurice Wood, director of research in the same department. All three are Society members.

Catalogued in the study are more than half a million problems presented by Virginia patients to 118 family doctors located in urban, suburban, and rural areas of Virginia, these visits encompassing a 2-year period, 1973-75.

The entire list of diagnostic categories compiled totals 567; of these, about two dozen accounted for one-half the visits. Medical examination for preventive purposes was highest in frequency. High blood pressure was second. Injuries (lacerations, amputations, contusions, and abrasions) were third. Sore throat was next, followed by acute bronchitis, sprains and strains, and diabetes. The common cold was eighth most frequent diagnosis, with obesity ninth, and influenza-like illnesses and colds with fever tenth. Then followed acute middle ear inflammation, depressive neurosis, Pap test, normal pregnancy care, anxiety neurosis, and hardening of the arteries (including heart/blood vessel disease.) Other leading diagnoses were female sex organ inflammations (nonvenereal), abdominal pain, congestive heart failure, urinary infection, sinus problems, respiratory problems, and forms of arthritis and rheumatism.

In an accompanying article, the journal's editor, Dr. John P. Geyman, characterizes the voluminous study as a "quantum jump . . . toward the definition of the content of family practice." Until this Virginia study, he says, "there has been little research in primary care in North America despite the fact that 90 to 95% of all doctor-patient contacts occur at this level."

The publisher is reprinting the study as a special supplement, priced at $6. Address the *Journal of Family Practice*, 292 Madison Avenue, New York NY 10017.

* * * * *

Surgeon Rahmat M. Seif, M.D., Roanoke, is quoted in a recent issue of Internal Medicine News in a report of a paper he presented at the annual scientific meeting of the Southern Medical Association in Miami. It was Dr. Seif's premise that solitary thyroid nodules should be routinely excised, since about one in five of such nodules may be malignant, according to his studies, and they are extremely difficult to evaluate other than by surgical means. Dr. Seif's paper reported a study of 264 patients at the Roanoke Memorial Hospital. Of these, 117 had solitary nodules and 76 had multinodular goiters. The incidence of malignancy was about 15% for those with solitary nodules and about 9% for those with multinodular goiter.

* * * * *

Dr. Jon B. Tingelstad and Dr. Louise W. Robertson, both of Richmond and both Society members, are the authors of an article printed recently in *CHEST*, the third consecutive issue of this handsome big journal to publish Virginia authors. Title of the article by Drs. Tingelstad and Robertson is, "Fluttering of the Interventricular Septum, the Result of Truncal Insufficiency." Presented is a case report of a child with truncus arteriosus and truncal insufficiency who had diastolic fluttering of the anterior mitral valve leaflet and left ventricular surface of the interventricular septum on echocardiogram. It notes that, although the fluttering has been described previously in patients with aortic insufficiency, it has not been reported with truncus arteriosus. The two authors are with the pediatrics faculty of the Medical College of Virginia. For reprints: Dr. Tingelstad, Box 291, Richmond 23298.

* * * * *

This month of March sees the accession to office of Dr. Jesse Steinfeld as dean of the School of Medicine, Medical College of Virginia, Richmond. Dr. Steinfeld brings to his new post the experience of an eminent oncologist and administrator. He is a former U. S. Surgeon General (1969-1973), serving also as chief U. S. delegate to the World Health Assembly in Geneva, and is recognized for his significant influence in the public alert to the relationship of cigarette smoking and lung cancer. President in 1970 of the American Society for Clinical Oncology, he is on the boards of many national organizations working in the cancer field and has served as governor of the American College of Physicians. He comes to Virginia from California, where he was professor of medicine at the University of California's College of Medicine, Irvine, and chief of medical services at the Long Beach Veterans Administration Hospital.

Dr. Andrew DeJarnette Hart, MSV member for 47 years and long beloved figure at the University of Virginia, Charlottesville, was the honore recently when the new Andrew DeJarnette Hart Conference Room of the department of medicine was opened. It was Dr. Hart who in 1938 organized the department of student health at the university, serving thereafter as its director. He was also professor of medicine, being named professor emeritus on his retirement in 1974, and conducted over the years a vigorous private practice. The new Hart Room was the gift of an anonymous donor. It can accommodate up to 40 persons for meetings and seminars.

* * * * *

John A. Board, M.D., Richmond, was published in the *Southern Medical Journal's* January issue. Title of his article: "Contraception with Norethindrone 0.35 mg Administered Continuously." For this study, microdose norethindrone (0.35 mg taken each day without interruption) was used as an oral contraceptive agent by 168 women for 4,264 months over a 5-year span. Seven pregnancies occurred with regular use and two with irregular use, resulting in a drug-effectiveness rate of 1.9 and a use-effectiveness rate of 2.5 per 100 woman-years. Dr. Board's address: Box 34, MCV Station, Richmond 23298.

* * * * *

Three gallant members answered the published plea for copies of the December *Virginia Medical Monthly*. They are Dr. Carl W. La Fratta, Richmond; Dr. P. Declan Burke, Culp; and Dr. C. C. Cooley, Norfolk. Thanks to these gentlemen, the journal records are now secure.

And as this page goes to press, copies arrive from Dr. Carol M. Rice, Sweet Briar College, and Dr. David I. Farnsworth, Richmond. Hurrah for them!

It's fairly embarrassing to report that the supply of February issues is also in short supply. That's a hint.

Dr. Fairfield Goodale, Jr., Richmond, has been appointed medical school dean of the Medical College of Georgia in Augusta, beginning April 1. He will leave the chairmanship of the pathology department at the Medical College of Virginia, a post he has held since 1963. He has also been editor of the *Medical College of Virginia Quarterly*.

* * * * *

Winner of $2500 in a recent national contest was Jean E. DeVries, operating room supervisor at the Alexandria Hospital, professional setting for many Society members in the northern Virginia area. She submitted this 1st place idea in a cost control contest sponsored by the Health Industry Manufacturers Association, Washington: use xray screening devices or metal detectors to monitor bed clothes, surgical drapes, and disposables for misplaced stainless steel instruments.

Richard D. O'Hallaron, Executive Director of St. Mary's Hospital, Richmond, won $500 and 3rd place for his suggestion to change the admission and discharge times of hospital patients by shifting the daily hospital census from midnight to noon. Mr. O'Hallaron gives credit for this idea to a group of physicians with whom he was discussing hospital problems. The doctors wanted patients admitted in the morning and discharged late in the day, such timing corresponding to "the way patients live." Taking the hospital census at noon, instead of at the traditional midnight hour, would make this entirely possible. It would also, Mr. O'Hallaron predicts, frequently save a day's hospital charge, the cost control benefit.

Mr. O'Hallaron tells this journal he has not yet had the chance to try out his plan, but he is working on it. For any doctor wishing to bring the idea to the attention of his hospital, he will be happy to spell out the details. St. Mary's address is 5801 Bremo Road, Richmond 23230.

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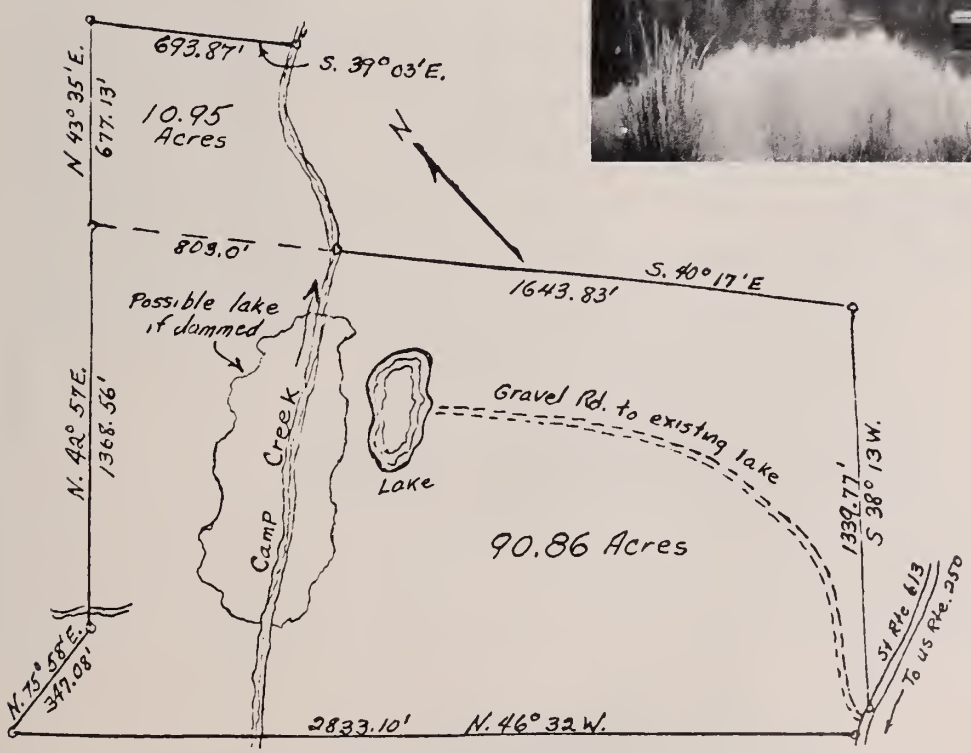
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In this issue:

"Malaise in Medicine," a Point of View

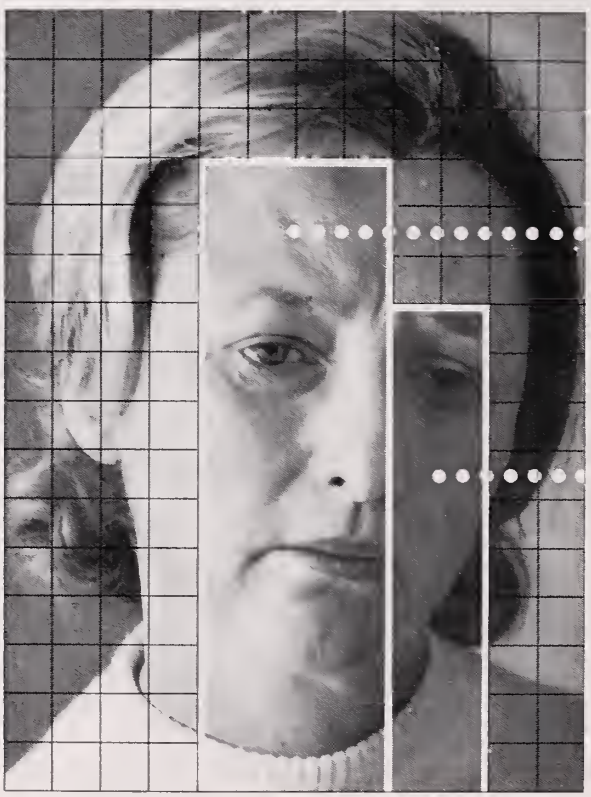
The Editor's "Ways and Means"

Proceedings of Council

Reports on Hodgkin's Disease,
Facial Fractures,
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Vol. 103
No. 4
APRIL
1976

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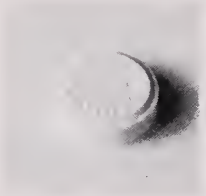
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequen and/or severity of grand mal seizures m require increased dosage of standard an convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ir gestion of alcohol and other CNS depres sants. Withdrawal symptoms (similar to those with barbiturates and alcohol) hav occurred following abrupt discontinuan (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Ke addiction-prone individuals under caref

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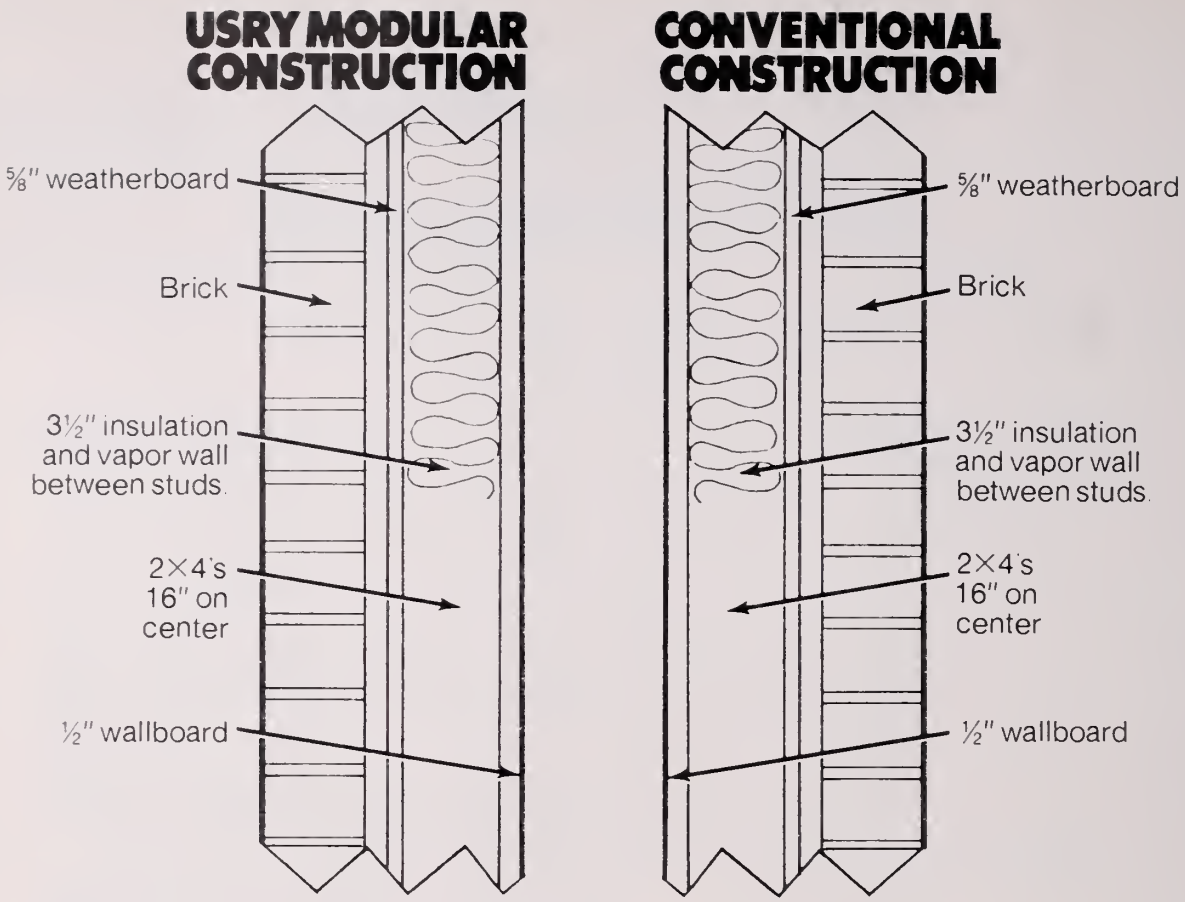
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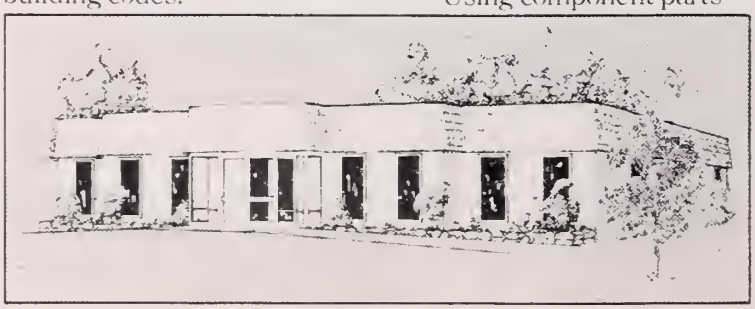
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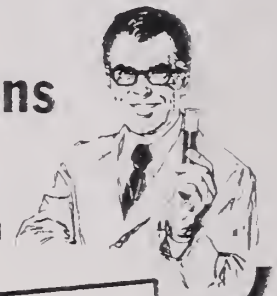
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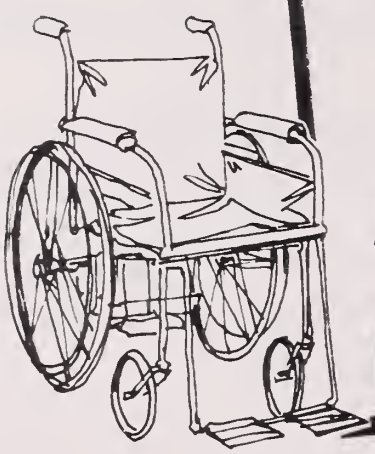
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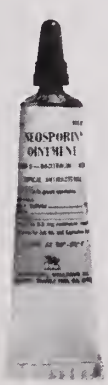
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Point of View . . . .

Malaise in Medicine

LOUIS W. HODGES
Lexington, Virginia

THERE is major unrest in the land over health care systems. That is neither good news nor bad news because it is not news at all. You, the doctors of Virginia, face the rising cost of malpractice insurance. You find the press reporting incompletely and with one bias or another the various history-making cases in modern medical practice. You must decide day in and day out what to advise your own patients to do with regard to their own health care; and, having advised them, you must decide whether you are both able and willing to help them carry out their choices. You know of PSRO and related efforts to achieve some kind of formal accountability on the part of physicians. You know of the pressures for continuing education for physicians as a condition for relicensure. In short, you know where the problems are, at least from the physician's point of view. You no doubt have discovered that the public's expectations of the physician are changing, and that simultaneously the physician's expectation of himself is undergoing revision.

When you reflect upon the current malaise, you may respond in anger or in frustration or in bewilderment or in hope or in some curious combination. Sitting as I do in the splendid isolation of the academy where I can view the current uneasiness at arm's length, with detachment, and even get paid for doing so, my own response to what is happening in modern medicine is one of both excitement and confidence. I know that there remains enough flexibility in the human mind that doctors can and will adjust to some new demands by society and patients, and I know that sooner or later the public can come to understand that physicians are neither demons nor saints. I know that when society places unreasonable or impossible demands on the medical community, we shall soon know they are impossible. We know that perfectly good solutions to real problems are indeed very rare—given the unavoidable limitations of the human mind and the unbounded expectations of the human soul.

In our society both physicians and patients are now facing some questions which are long overdue, especially concerning life's pivot points, birth and death.

Given the uncertainties and changes which face us, it should surprise no one that, unlike Doc Adams of Dodge City, you are not always held in reverential awe! At this time that may be sharper in your mind than the correlative fact that you are not always held to be possessed of horns and a forked tail.

The problem areas clearly include abortion, genetic engineering, in vitro fertilization, euthanasia, and experimentation on human subjects. We have not faced adequately the question of who should decide these issues. We have not given adequate attention to the human right to health care, nor to the design of a health care delivery system which could guarantee it. We have a great deal of unfinished business in medical ethics. It arises at the point at which medical possibility intersects with human desirability.

We have always had to face questions of this magnitude in medicine. Why then the current

---

Mr. Hodges holds two posts at Washington and Lee University, Lexington. He is Professor of Religion, and Director of the Society and the Professions: Studies in Applied Ethics, an undergraduate program designed to integrate the liberal arts curriculum with preprofessional training in medicine, law, and journalism. It is funded by the Lilly Endowment.

Presented in part before the Roanoke Academy of Medicine on November 3, 1975.

unrest? What are the roots of what I have called the "malaise in medicine"? What are the forces in the medical community which give rise to a new interest in medical ethics? I believe that a sharpened perspective on these larger forces is prerequisite to our dealing effectively with the concrete question of ethics and practice. Let me suggest four roots of the current malaise.

"At the head of the list is the medical community's amazing success."

At the head of the list is the medical community's amazing success. Dr. Joseph Fletcher is fond of pointing out that it is precisely the tremendous advances in our medical capability, coupled with doctors' genuine concern for the well-being of the patient, which give rise to the demanding questions we must now answer. If you reflect but a moment on what medical practice would be like if we did not have available to us the respirator, or what medical practice might be like if we do get the EMI, it is readily apparent that your fantastic success and your continued efforts on behalf of the patients are preconditions for raising our biggest questions. Obviously if we did not have vast technical capabilities and exceedingly refined skills, many of our questions would never arise. On the other hand, if suddenly we were to remove from the scene the devotion of the medical community to improve medical practice, questions of medical ethics would have utterly no relevancy to doctors. I want by this route, therefore, perhaps in sermonic fashion, to urge you to remember that medicine and morals are absolutely inseparable. Every important technological innovation in medicine roots finally in somebody's vision of the better life through better health.

Technological innovation and refinement of medical skills do come upon us, however, like every other significant advance in man's control over his own destiny. The skills and the technology always arrive before rules to govern their employment can be forged. The respirator, no less than atomic fission, for example, can aid us in achieving the better life. But again, like atomic fission, it also can add to the already pressing weight of human misery. The Quinlan case demonstrates this. Man's knowledge ordinarily leads to an enhancement of man's power to affect his own destiny. The rapid gains of our knowledge and skills in recent years have placed you and me in the role of trying to decide on the guidelines for the humane use of that newfound power. Thus if we do face now a malaise in modern medicine, we can greet it with the confidence that it is a mark of success.

A second root of the current excitement in medicine is the fact of radically changed consumer expectation. The consumer is redefining the doctor's role. It has been claimed that we live in an age of consumerism. It is further claimed that our success in systems of education in this country has produced better knowledge on the part of the consumers about health care and what might rightfully be expected from physicians. In addition to having a much more literate consumer than we had 100 years ago, modern systems of mass communication call every patient's attention to possible claims against doctors. The media also provide highest visibility for the physician who has made serious mistakes or miscalculations, or who has been plainly incompetent. In these and in a variety of additional ways, we may claim success in education which makes patients more qualified and determined to participate actively in decisions about their own medical future. (In the short run, that note of self-congratulation about the success of education must give little comfort as you pay your insurance premium!) It remains true, nevertheless, that the modern patient is both more able and more concerned than was his counterpart of a generation back to participate actively in decisions about his own health and life.

"The consumer is redefining the doctor's role."

Another way of saying this is that heretofore the physician enjoyed a status that authorized him to make both medical and moral judgments for the patient. The patient turned over to the doctor full responsibility for his health. The doctor was able both to predict what was medically possible and to decide *for* the patient what was medically desirable. That day is now past. He still is looked to as the only available authority on what is medically possible. But he is no longer allowed single-handedly to decide what is medically desirable for a given patient.

So it is that changed consumer awareness and modified consumer expectations are effectively depriving the medical doctor of one role to which he has grown accustomed. His word remains law as regards medical matters, but it is no longer binding when it comes to matters of the selection of the best alternative among several possible ones. The patient wants to know his options, and sometimes his doctor's advice.

The patient, the consumer of your services, is not altogether unlike the student, the consumer of my services. He knows more and insists on participating more fully in decisions that affect his own life.

However much we may regret or welcome the change in the physician's role, it seems to me that on balance we are moving in the right direction. Medical judgments themselves are clearly tricky enough. To be qualified to make them requires more training, more time, and more diligence than ever before. In my view it is enough to expect a person to have adequate medical knowledge and to be a skilled practitioner of medicine. It is too much to ask

"Give me a doctor who is willing to leave the value choices up to me."

that one person be able also to make moral judgments for the patient as well. Speaking from the point of view of a patient I pray to be delivered from that doctor who always has my best interest at heart but who is medically incompetent. Give me instead a doctor of thorough medical competence who is willing to leave the value choices up to me.

A third root of the current unrest in the medical community is an unfortunate though perhaps unavoidable byproduct of the unprecedented growth of medical specialities.

"Medicine and morals are inseparable."

One of the humanly necessary byproducts of specialization is an increased sense of distance and alienation between the doctor and the patient. The patient in a modern hospital, particularly that patient who is seriously ill, never seems quite to know who is really in charge. The patient who is seen by this specialist and by no one doctor for an extended period of time, gets the distinct impression that he or she is in the hands of a committee and that the chairman of that committee just died! I do not wish to dwell on this point; it is already sufficiently obvious. I would suggest that in this kind of team care someone with both medical and psychological skills be made a part of the team and have the primary function of informing the patient about his status. Someone with medical knowledge and status should answer for the patient those questions which, if left unanswered, lead to serious uncertainties and even to doubts about the competence of medical care. We need to reduce the sense of alienation from specialists. They cannot be like the old family doctor, but someone needs to be.

Fourth, as medical techniques become more and more complicated, so must the law which governs the conduct of a doctor. This fact is both a cause and an effect of the current malaise. When a dispute arises between the doctor and patient, such as exists in the Quinlan case, the only available instrument for settling that dispute is recourse to law. In my view the courts are peculiarly ill equipped to deal with questions of medical ethics and to decide on the proper course of action toward a given patient. Nevertheless, they are our only available instrument. Moreover, it is quite clear that someone must decide about how to treat

dying patients. To take one example, we have a capacity to maintain organic function long after a person has died. In an earlier day the laws could be simple, in that personal existence and organic existence were essentially coterminous. Now that they are not, decisions

"The days of the solo practitioner being able autonomously to decide not to respirate a newborn defective are gone."

have to be made about proper courses of action toward the patient in the interim between the cessation of personal function and the cessation of organic function. The decisions which must be made in this area are not medical but moral. The question raised is not merely what can be done to keep the organism functioning but rather, when is it humanly desirable to do so?

Now, if we assume that law will increasingly become an instrument for the regulation of professional conduct, we know that we are in for more trouble ahead. Legislatures and courts of necessity move very slowly. In moving at all, missteps are highly likely. Efforts to state the *rights* of the patient and the *rights* of the physicians can never be separated fully from the questions of the *desires* of the patient and the *desires* of the physician. That separation is just as difficult for legislators as it is for doctors or academies of medicine.

When facing the prospect of lawyers and politicians entering the arena even more than they now do, one may properly shudder. The fact remains, however, that the days of the solo practitioner being able quietly and autonomously to decide not to respirate a newborn defective are forever gone. Since modern health care is a team effort, the doctor in effect practices medicine in a fishbowl. No longer can he afford to solve hard problems of defective babies and dying patients by the route of solitary and benign neglect. The harsh reality of this fact Dr. Edelin experienced directly.

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Ga-67 Staging of Hodgkin's Disease

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A simple, noninvasive means for evaluating areas of probable involvement with Hodgkin's disease would be welcomed by patient and physician alike. The authors report their experience with Gallium-67 scanning and discuss its usefulness as such a means.

THE importance of accurate clinical staging of Hodgkin's disease prior to treatment has gained added significance in recent years because of the possibility of cure with aggressive radiotherapy. The value of x-ray therapy in improving survival of Hodgkin's disease was suggested by Craft[1] in 1940 and popularized by Peters[2] ten years later. More recent papers[3,4] have suggested that cure of Hodgkin's disease can be achieved with radiotherapy. Kaplan[5] has emphasized that the frequency of relapse in an irradiated field is inversely related to the dose, and has demonstrated that with a dose of 4000 rads the relapse frequency in that field approaches zero. Statistical studies[6] reveal that most relapses occur within the first three years of treatment; and after a 5-year relapse-free period, the chance of relapse is less than 5%. It follows, therefore, that if sufficient irradiation can be delivered to all areas of involvement, Hodgkin's disease can be cured with radiotherapy.

To obtain the necessary information regarding all possible areas of involvement, patients with Hodgkin's disease may experience an extensive, uncomfortable and expensive workup. This evaluation in many medical centers includes the following tests: blood tests, bone marrow aspiration and/or biopsy, chest film and/or mediastinal tomography, metastatic bone survey, inferior vena cavogram with excretory urogram, lymphography, exploratory laparotomy with liver and lymph node biopsies plus splenectomy. A simple, noninvasive means for evaluating all areas of probable involvement with Hodgkin's disease would be welcomed by patient and physician alike.

Edward and Hayes[7] in 1969 demonstrated that ^{67}gallium-citrate (^{67}Ga) localized in the involved nodes of a patient with Hodgkin's disease. Additional papers[8-11] have confirmed this observation. The purpose of this paper is to report our experience with ^{67}Ga scanning and to discuss its role in the staging of patients with Hodgkin's disease.

Materials and Methods

Patients with biopsy-proven lymphoma who were referred to the Division of Nuclear Medicine, Medical College of Virginia Hospital, were evaluated with ^{67}Ga scanning. The control group consisted of four normal volunteers and 12 lymphoma patients who were in complete remission. Thirty patients with untreated Hodgkin's disease were evaluated. They were staged according to the modified Rye system[12] and were histologically classified by the method of Lukes and Butler.[13] All patients had a positive node biopsy, but additional peripheral nodes were considered to be involved, based on palpation in most cases.

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Mediastinal and extranodal involvement (lung and stomach) were determined by radiographic procedures. In 19 patients, subdiaphragmatic disease was evaluated by abdominal laparotomy with hepatic and nodal biopsies and splenectomy.



Fig. 1. Ga-67 scan in a patient with Stage IV B Hodgkin's disease, showing uptake of radioactivity in the cervical, mediastinal, hilar, para-aortic, and ilio-inguinal nodal regions.

All patients were injected intravenously with ^{67}Ga, 40 uCi/kg body weight (a maximum dose of 3.0 mCi was not exceeded). To clear the gastrointestinal tract of radioactivity, each patient received milk of magnesia plus senna extract orally and a sodium phosphate enema prior to scanning. The scan was performed 48 hours after the administration of ^{67}Ga, using a rectilinear scanner with a low energy 3-inch focusing collimator. A spectrometric setting of 160-320 keV was used to encompass the 184 and 296 keV photopeaks of ^{67}Ga. Patients were scanned anteriorly in the supine position from the head to the groin. Special views were obtained when clinically indicated.

Results

The distribution of tissue uptake of ^{67}Ga in the control group was variable. The liver concentrated ^{67}Ga in all subjects. Waldeyer's ring, spleen, and colon were visualized approximately 50% of the time. Other areas which accumulated ^{67}Ga to a variable degree included the salivary glands, sternum, female breast, skeleton, and external genitalia.

The scan of a patient with Hodgkin's disease (Stage IV B) is illustrated in Figure 1. There is ^{67}Ga uptake in the cervical, mediastinal, hilar, paraaortic, and ilio-inguinal node regions. A chemotherapeutic remission was achieved; his repeat scan (Figure 2) shows only normal activity in the nasopharngeal lymphoid tissue, sternal area, and liver.

The results of ^{67}Ga scanning of the patients with active Hodgkin's disease, classified according to histologic type and clinical stage, are shown in Table 1. Positive scans were observed in all four histologic types of disease and in patients with each stage, regardless of the absence or presence of systemic symptoms. Overall, 87% of the cases studied had positive scans. The four patients who failed to concentrate ^{67}Ga in any site of involvement included two patients (Stage I A) who had excisional biopsies and one patient (Stage IV B) who had a negative scan on two separate occasions. The fourth patient (Stage I A) with a negative scan failed to

concentrate ^{67}Ga in a biopsy proven area which contained residual disease.

The 30 patients had 76 sites which were involved with disease. Of these, 66 sites concentrated ^{67}Ga (Table 2). The percent of positive scans with respect to nodal regions varied from 74% to 100%. In all four cases of extranodal involvement (three lung and one stomach) the scan was positive.

Nineteen patients had exploratory staging laparotomy following their scans (Table 3). Evaluation of abdominal lymph node involvement revealed the scan to be correct in 16/19 patients. One patient with a false negative scan had only one high aortic node involved at laparotomy. Radioactivity in this area may be obscured by the normal uptake of ^{67}Ga in the left lobe of the liver. The other patient (Stage IV B) with a negative scan failed to concentrate ^{67}Ga in any diseased site on two separate occasions. Detection of splenic involvement with Hodgkin's disease by scanning with ^{67}Ga revealed an accuracy of 63%. There were 12 correct, three false positive, and four false negative scans of the spleen.

In control subjects and Hodgkin's disease patients, hepatic uptake of ^{67}Ga occurred. The hepatic distribution of radioactivity was similar in both groups except for an occasional patient with Hodgkin's disease in whom hepatic uptake was diminished because of such extensive nodal uptake (Figure 1). There was no pattern of hepatic ^{67}Ga uptake which was helpful in distinguishing normal livers from those that were involved with Hodgkin's disease.

Discussion

Gallium-67 scanning offers a simple, noninvasive means of evaluating patients with Hodgkin's disease. In our study, 87% of patients with active disease had positive scans, and 84% of clinically involved sites showed abnormal uptake of ^{67}Ga. Other investigators[8-11] have reported similar results with ^{67}Ga scanning of patients with Hodgkin's disease. Of 312 patients studied, 263 had abnormal scans. Accuracy in determining sites of involvement ranged from 65 to 82%.

It is readily apparent that the scan is neither positive in all patients nor in all sites of involvement in any one patient with Hodgkin's disease. The reason for our inaccuracy rate of 15% cannot be explained completely with our present knowledge of ^{67}Ga metabolism. False



Fig. 2. Ga-67 scan in the same patient two years following a chemotherapeutically induced remission. There is normal Ga-67 uptake in the nasopharyngeal lymphoid tissue, sternal area, and liver, but no uptake in the previously involved nodes.

negative scans were observed among patients with nodular sclerosis and mixed cellularity types; with Stages I and IV, regardless of the presence or absence of systemic symptoms. Although the number of patients in each category is too small for valid statistical analysis, the data do not suggest that histologic type or stage of disease is a determining factor in ^{67}Ga uptake. The exact mechanism of cellular uptake of ^{67}Ga is not known. Bickel and Hansen,[14] however, reported that the cellular incorporation of ^{67}Ga is related to, or possibly dependent on, the rate of cellular proliferation. This observation cannot explain our false negative scans, for in our series, the patient who had the most rapidly progressive disease had a negative scan initially and also six months later, when a relapse occurred following a chemotherapeutic induced remission. Finally, false negative scans occurred in areas in which the size of the involved node was within the resolution of our detecting system.

TABLE 1. RESULTS OF ^{67}GA SCANNING: CORRELATION WITH HISTOLOGY AND STAGE OF HODGKIN'S DISEASE

	No. Cases	No. Positive Scans
A. Histology		
Nodular Sclerosis	15	13
Mixed Cellularity	10	9
Lymphocytic Predominance	2	2
Lymphocytic Depletion	1	1
Unknown	2	1
TOTAL	30	26
B. Pathologic Stage		
I	7	4
II	12	12
III	2	2
IV	9	8
C. Systemic Symptoms		
Absent	18	15
Present	12	11

The purpose of staging Hodgkin's disease is to determine all areas of involvement. Since our data and that of others show that ^{67}Ga scanning is not 100% accurate, does such a study have a role in staging Hodgkin's disease? More careful evaluation of our data reveals certain limitations of ^{67}Ga scanning, which, when interpreted in light of the clinical picture, make the ^{67}Ga scan more useful than the raw data suggest. Gallium-67 scanning of peripheral nodes had the greatest false negative rate. All peripheral nodes suspected of involvement were not confirmed histologically; however, these lymph nodes are relatively accessible to biopsy if there is a question of involvement. Mediastinal involvement can be determined with chest x-ray and/or mediastinal tomography. Using the roentgenogram as proof of nodal involvement, the ^{67}Ga scan was positive in all 12 patients in our series. Others,[8-10] have reported that 139 of 156 patients with x-ray evidence of mediastinal involvement had abnormal ^{67}Ga uptake in the mediastinum.

Determination of involvement in areas of relative nonaccessibility such as the abdominal nodes, liver, and spleen, represents the difficulty in accurately staging Hodgkin's disease. Noninvasive means of evaluating abdominal nodes include lymphography and inferior venacavograms. These radiographic studies,[15,16] when correlated with laparotomy and biopsy, have a combined false positive and false negative rate of 25-36% and 3-12%, respectively. In the study by Johnson et al[10] lymphography was compared with ^{67}Ga scanning of patients with histologically proven abdominal nodal involvement. Each procedure depicted nodal disease missed by the other, but the ^{67}Ga scan was slightly more sensitive and accurate than lymphography. Since laparotomy with biopsy now is considered the most accurate method of determining abdominal node involvement, the scans of our patients were compared with the



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Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

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Sleep Stages

- Awake
- REM
- Stage 1
- Stage 2
- Stage 3
- Stage 4



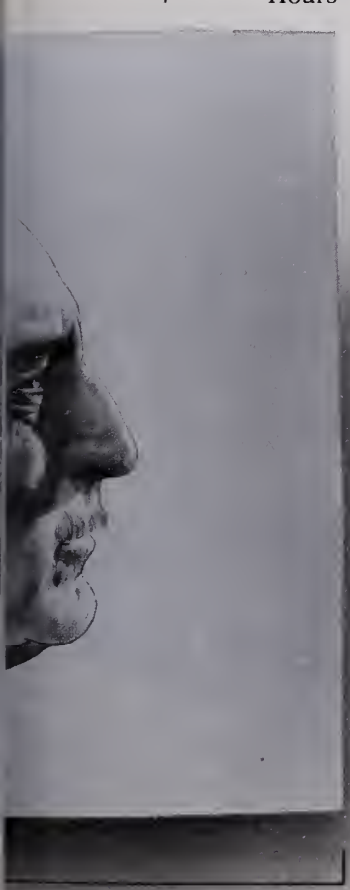
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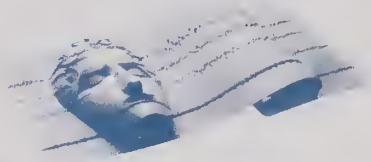
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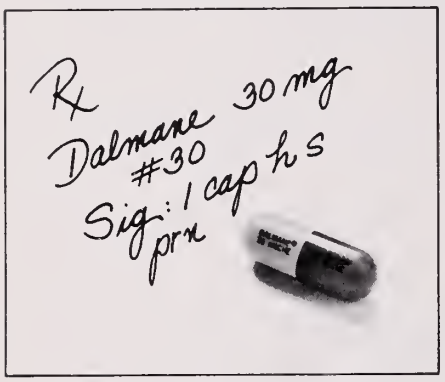
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- ☐ reduces nighttime awakenings
- ☐ lengthens total sleep time

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Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

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TABLE 2. RESULTS OF ^{67}GA SCANNING: CORRELATION WITH CLINICAL NODAL INVOLVEMENT IN HODGKIN'S DISEASE

Site	No. Clinically Positive	No. Positive Scans
Cervical	19	14
Clavicular	12	12
Axillary	9	7
Mediastinal	12	12
Para-aortic	9	8
Ilio-inguinal	11	9
Extra-nodal	4	4
TOTAL	76	66

results of abdominal exploration. Nineteen patients had a staging laparotomy following ^{67}Ga scanning. Our data show that the scan was correct in predicting the presence or absence of subdiaphragmatic nodal involvement in 16 out of 19 patients. There was one false positive and two false negative scans. The false positive, in retrospect, probably represented normal activity in the spine and colon, which was misinterpreted as ^{67}Ga uptake in para-aortic and/or iliac nodes. One patient with a false negative abdominal scan had only one high aortic node involved. The activity in this area was obscured by the normal concentration of ^{67}Ga in the left lobe of the liver. The other patient with a false negative scan failed to take up ^{67}Ga in any area of involvement on two separate occasions. Likewise, Kay and McCready[8] showed a high correlation between ^{67}Ga scan results and surgical findings at laparotomy. The scan was correct in 35 of 40 patients with abdominal nodal involvement. However, the cooperative study reported by Johnson and associates[10] found that scanning demonstrated ^{67}Ga up ake in just 50% of the diseased nodes that were de[illegible]cted at laparotomy. Although the rate of c[illegible]ction of subdiaphragmatic nodal involveme[illegible] with Hodgkin's disease appears to be variable depending on the study, a positive scan correlates well with the presence of disease.

Noninvasive methods for determining hepatic and splenic involvement with Hodgkin's disease have been disappointing. Standard scanning of these organs with ^{99m}Tc-sulfur colloid has been interesting but not helpful in accurately detecting disease. Milder et al[17] showed that the liver scan size correlated nonspecifically with stage but not with involvement with Hodgkin's disease. Likewise, splenic length correlated with the stage of disease independently of tumor involvement. Although all spleens greater than 15 cm in length were positive for tumor, overall there was scan-pathology disagreement in 23% of abnormal scans and in 40% of normal scans. Similarly, ^{67}Ga scanning proved to be of no value in predicting the presence of Hodgkin's disease in the liver or spleen. The liver normally concentrates ^{67}Ga, and the distribution of radioactivity within the liver was not different from that of the diseased livers. When scanning anteriorly, splenic activity was noted in 50% of our normal controls. In the active disease group, the ^{67}Ga scan was correct in 12 of 19 patients with essentially equal numbers of false positive and negative results.

Of the 30 patients evaluated, four had extra-nodal involvement. In all four cases, the

TABLE 3. RESULTS OF ^{67}GA SCANNING: CORRELATION WITH STAGING LAPAROTOMY

	True Positive	True Negative	False Positive	False Negative	Total Percent Correct Scans
Abdominal Nodes	6	10	1	2	84
Spleen	4	8	3	4	63

^{67}Ga scan depicted the lung or gastric disease. Other investigators,[8,9,11] also have reported a high degree of accuracy in detecting extranodal Hodgkin's disease.

Summary

Gallium-67 scanning of patients with Hodgkin's disease offers a simple, noninvasive method of evaluating the extent of disease prior to treatment. The accuracy of the scan approaches 85% with some variability depending on the site of involvement. Mediastinal and extranodal disease were routinely detected with ^{67}Ga scanning. Abdominal node involvement was found at laparotomy when the scan was positive. However, because of a low but significant rate of false negative results, a negative scan cannot be interpreted with certainty as absence of disease. Unfortunately, similar to other noninvasive tests, ^{67}Ga scanning was unable to determine the presence or absence of hepatic or splenic involvement. Even with these limitations, ^{67}Ga scanning provided useful, additional staging information in a selective number of our patients. Although our initial studies are encouraging, we will have to await further experience with ^{67}Ga scanning to determine its role in the overall work up and staging of patients with Hodgkin's disease.

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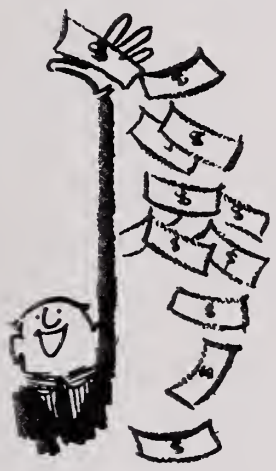
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UNLESS the public has quick and easy entry into an emergency medical system, the most sophisticated life support techniques are ineffectual. The most widely used method of reporting emergencies is the telephone. The number 911 is designated for public use throughout the United States to request emergency aid from fire, police, or rescue agencies. Today there are 30 million Americans in over 500 communities who have 911 as their emergency telephone number, and in Great Britain a national emergency telephone number (999) has been functioning with great success for more than 30 years. Yet to date only three counties in Virginia have installed this valuable emergency aid.

The first 911 telephone system in Virginia was installed in Prince William County, where all 911 calls are answered in Manassas. The system is unusual in that only fire and rescue services respond to it, the police retaining their seven-digit numbers. In 1969, after hurricane Camille, a 911 system was installed in Nelson County, designed to be answered by the sheriff's office in Lovingston. Another 911 system was initiated in Shenandoah County in 1973, where all emergency calls for rescue, fire, and police are answered by the sheriff's office in Woodstock. By November, 1976, Greene and Fluvanna Counties will have 911 service.

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The use of the universal number 911 provides immediate public access into the emergency system. The numbers are easily located on a telephone and can even be dialed in the dark. Without it, a person must search among a confusing array of seven-digit numbers for the needed emergency agency; often, there are different numbers for daytime and nighttime, and in some counties, residents must make long distance calls to request emergency aid! In contrast, the 911 system utilizes toll-free local calls; even public pay telephones can be modified to accept a 911 call without a coin.

The most important benefit of a 911 service is the reduction in the emergency service response time, and the shorter the response time, the faster the arrest can be made, the more swiftly the fire extinguished, the more quickly a victim resuscitated. With a 911 system, one does not have to look up a number, or wait for an operator, or search for dimes for a pay phone.

When an accident occurs, there is often need for multiple safety agencies. The single 911 number eliminates the need for multiple calls; and by having a central answering point, the community's emergency services can better coordinate their responses to cries for help. All 911 calls are received by expert dispatchers especially trained to handle emergencies and knowledgeable about the jurisdictions they serve.

Here are some guidelines to follow for the installation of a 911 system in your community.

A task force should be formed with representatives from the police, sheriff, fire, rescue, civil defense, medical services, local government, and telephone companies. This planning phase can be expedited by consultation with the designated state agency for the coordination of 911 activities, the Virginia Public Telecommunications Council, 902 Ninth Street Office Building, Richmond VA 23219; with your local Emergency Medical Services Council and your local firemen's association.

The task force should review all of the existing literature[1-3] *and visit operational 911 systems in Virginia.*

Decisions should be made regarding areas to be served by the 911 system, by surveying the radio and telephone systems among the emergency agencies in your community and by correlating the area served by your telephone company with these agencies' jurisdictional fields.

An inventory of all emergency services should be made. The goal is immediate public access to all public safety agencies. These agencies should be encouraged to participate in planning. Mutual aid agreements should be established.

The location of the answering and/or dispatching center must be selected. Most communities have an emergency answering location for police, fire, and rescue; if there is more than one such location, a common location must be established. The impact of a community disaster on the system's operation must also be considered.

Toward the end of planning, *a request should be made to the appropriate telephone companies for cost feasibility studies.* This request is usually made by the county government. Telephone companies will provide this study free of charge. The cost for maintenance of a 911 system is proportional to the population; it is slightly higher than for seven-digit numbers, but the benefits of the 911 system to the acutely ill patient or distressed caller are so irrefutable as to justify this additional expense. Nelson County, with a population of 14,000 and the incorporation of sheriff, fire, and rescue services, pays $90 per month. For Prince William County, where the population is 155,000 and fire and rescue calls are answered by the system, the monthly charge is $780. If this seems high, one must remember that the larger the population, the more the emergency calls—and the higher the potential for saving lives.

Finally, in implementing the 911 system, it is important to know that a new 911 system tends initially to encourage a greater volume of calls than is normal. It is wise to schedule service to begin during a period when the number of calls may be forecast as minimal. Also, a publicity campaign must be mounted to inform the public about the new 911 service. To avoid the use of the number before it is operational, the publicity should be timed to precede implementation by no more than two weeks.

A universal 911 telecommunications system is a vital component of a responsive emergency medical system. Virginia needs more of these 911 systems, until finally this quick and easy call for help is available to all Virginians.

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The Training of the Emergency Medical Technician

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ONE of the major goals of an emergency medical system (EMS) is to bring the hospital to the acutely ill patient. An essential ingredient of this system is the emergency medical technician (EMT) who delivers health care to the patient at the scene of the accident. The performance of the technician will often considerably influence patient morbidity and in some cases mortality.

In the Commonwealth of Virginia, the rescue squadsman is the EMT. Rescue squads in Virginia have had a long and proud history. Virginia led the country in the development of volunteer rescue squads, the first one originating in Roanoke in 1928. Since that time, numerous other squads have been conceived and born, and thousands of men and women in Virginia have continued to give their time unselfishly to care for acutely ill patients.

The success of health care administered by the EMT will be dictated largely by the technician's training. This report outlines guidelines for developing comprehensive training programs for the EMT in the Commonwealth of Virginia.

Bureau of Emergency Medical Services

In 1968, the Bureau of Emergency Medical Services was established in the State Department of Health in Richmond. Its purpose was to upgrade Virginia's emergency medical care. Until that time, the volunteer squads had only to meet self-imposed standards. One of the major responsibilities of this office is the certification of all EMT's in the state. Each candidate must comply with certain standards before certification. The rescue squadsman must be 18 years of age or be a person of mature judgment. This person must be of sound physique, good eyesight, and not subject to epilepsy, vertigo or heart trouble or any defect that would render him unfit for duty. The squadsman or woman must be able to read, write and speak English. Addiction to drugs or intoxicating liquors or conviction of a felony involving any sexual crime precludes certification.

Selection of Students

When an emergency medical technician training program is initiated, priorities for selection of students should be defined. The graduates of the program should fulfill the immediate needs of the rescue squads. Before initiating a training program, all rescue squads should be consulted regarding staffing problems. In general, the squads are faced with shortages in personnel during the weekday. For that reason, the highest priority for training should be those willing to serve on rescue squads during the daylight hours. In most cases these are housewives. When the personnel needs of the rescue squads are satisfied, the next priority should be the training of members of other public safety agencies, as well as health care personnel in industrial complexes.

The enrollment in the course should be limited to 40 students or less. However, it is important to point out that the quality of the educational program is inversely related to class size, particularly with regard to the practical training.

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Supported by contract from the Department of Health, Education and Welfare, Philadelphia.

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Approval of Course

The design of the curriculum for the EMT training program must meet with the approval of the Bureau of Emergency Medical Services of the State Department of Health. Upon request, the regional training officers of the Bureau of Emergency Medical Services will assist in program design and implementation. Each training officer has the responsibility for EMT training in specific geographic areas and is readily available for consultation.

Training Program

In Virginia, ambulance attendants must have successfully completed either an advanced first aid and emergency care course given by the American National Red Cross, or the EMT training program. While the Red Cross Advanced First Aid training program is supported by standardized courses of instruction, its primary purpose is to serve as basic training for the lay person rather than the rescue squadsman. Generally, this course is not considered adequate for those who are required to render care and transportation to persons who are seriously ill.[1] The Red Cross Advanced First Aid Course, which takes 52 hours for completion, has some notable deficiencies. The curriculum of the course does not include cardio-pulmonary resuscitation (CPR), the use of oxygen equipment or mechanical adjuncts to breathing, all essential basic life support techniques. In addition, discussion of the anatomy and pathophysiology of disease is extremely limited, hampering the student's understanding and interpretation of the illness.

In 1966, the report of the National Academy of Sciences/National Research Council called for the development of emergency medical training courses, manuals, and aids for the EMT. The Department of Transportation's National Highway Safety Administration met this recommendation by contracting with Dunlap and Associates to prepare a training course. The text for the course is *Emergency Care and Transportation of the Sick and Injured,* published by the American Academy of Orthopaedic Surgeons. An instructor's teaching manual published by the Department of Transportation provides lesson plans for the course. Slides (2″ x 2″) consisting of photographic duplications of many of the figures in the text are valuable teaching aids. The Robert J. Brady Company, Bowie, Maryland 20714, has also developed a textbook, instructor's manual, and audiovisual aids. The chief value of this supplementary educational resource is the study questions in the instructor's manual that aid the student in understanding the material. The curriculum for this special training course includes 71 hours of classroom training and 10 hours of inhospital training. Each lesson is initiated by a didactic lecture followed by a practical training session.

Scheduling of Course

The full time employment of most volunteer rescue squadsmen requires them to work during the day. Evenings and weekends remain as the only possible hours for their course participation. Two evenings per week over a 3-month period is the maximum amount of time that the majority of students can devote to this educational program. Occasionally, practical teaching sessions such as extrication and lifting and moving patients are more adequately undertaken during daylight hours. In these cases, classes could be scheduled during the day on Saturday or Sunday.

Educational Affiliation

Each training program should be integrated into the curriculum of an established educational institution. This approach has obvious mutual benefits. It supports and adds a new dimension to the already established allied health program in that institution. The audiovisual equipment at the institution can be utilized in the teaching sessions strengthening the program. In addition, the students registered in the program can take the course for credit in their pursuit of a baccalaureate degree. Approval of the course for academic credit is in

itself an endorsement of the program by the sponsoring academic institution ensuring a high caliber of education.

Our EMT training program is part of the curriculum of the Piedmont Virginia Community College. Other community colleges in Virginia have also established similar training programs for the EMT. The convenient geographic distribution of community colleges makes them ideal centers for formal EMT training, as well as for continuing education of rescue squadsmen or women. Therefore, we recommend that all community colleges in the Commonwealth of Virginia offer this course and thereby become the responsible centers for EMT education.

Equipment

The instructor's manuals have comprehensive lists of all training equipment. Hospitals and rescue squads have all of the necessary equipment, with the exception of the manikins for CPR training. A certified American Heart Association instructor can obtain the CPR manikins on loan from the Virginia Heart Association, 316 East Clay Street, Richmond, Virginia 23219. The Virginia Heart Association must be notified six weeks prior to CPR training sessions to allow adequate time for shipment.

Instructors

Physicians, emergency room nurse practitioners, and lay instructors are authorized to teach the course. The use of lay instructors in the training of EMT's has been extremely valuable, particularly in rural communities. In these regions, the physicians are usually overcommitted with the demands of health care delivery. This additional responsibility of EMT education is often untenable. For that reason, the Bureau of Emergency Medical Services has trained lay instructors to teach the EMT course. To become a lay instructor, the individual must have successfully completed an 81-hour EMT training course approved by the Bureau of Emergency Medical Services. The squadsman or woman must have five years of experience in an EMS agency. This requirement can be waivered in some cases. The individual must pass an essay and multiple choice test and attend a 32-hour instructor's course. Following completion of the course, the lay instructor must teach one EMT course or two refresher courses within two years to maintain his certification as a lay instructor.

We recommend that all teachers of the EMT training program be American Heart Association instructors in basic cardiac life support. This will ensure that their students will receive the most current training in CPR. As a result of this training, each EMT will be certified as a Basic Rescuer by the American Heart Association.

Design of Training Program

The course should be designed by the physicians, nurses, and lay instructors so that the graduates of the program can deliver optimal care to the acutely ill. The trainees must learn sufficient factual information so that they can make correct decisions. Once the decisions are made, they must be able to execute the necessary practical measures to care for the acutely ill.

The design of the training program should be altered to satisfy the needs of each individual student. The backgrounds of squad trainees differ considerably. Some are young men or women whose recent completion of extensive educational programs make them very adept in comprehending didactic teaching. These individuals usually score well on their written examinations. Others have not attended an educational program for many years and feel uncomfortable in this new setting. Yet many of these same individuals will excell in the practical training.

The use of study questions considerably aids students in comprehending the lessons. We have prepared a series of 250 study questions that were given to each student at the beginning of the course. These questions illustrated the important points of the lectures. In addition, they prepared the trainees to take



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

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written examinations which were essential for successful course completion.

The success of our practical training of the EMT was disappointing. The reasons for this are several. The practical training is routinely taught after the didactic lecture late in the evening. Furthermore, practical training often necessitates that individual attention be paid to each student, which was impossible for a large class of 37 students. These circumstances led to an unsatisfactory performance of six of our trainees in their final practical test. In all cases, failure in the practical test was related to their performance rather than to their treatment selection. For instance, students correctly suspected spinal cord injury, but were unsuccessful in their delivery of health care.

The need for improved practical educational techniques is, therefore, painfully apparent. We are now developing educational modules on videotape that demonstrate each practical technique. These educational modules are designed so that each student can interact with each lesson plan, facilitating learning of practical skills. Utilizing these educational resources, repetition of practical exercises should allow each student to master these techniques, becoming a polished deliverer of health care.

Examination

Upon the completion of the course, certification is dependent upon passage of a practical and written examination administered by the Bureau of Emergency Medical Services. Successful completion of these examinations allows the EMT to be certified for a 3-year period. A 20-hour refresher course must be taken at the end of this time interval to maintain certification.

Uniform standards for training, testing and certification should be established in our state as well as throughout the country. Establishment of such standards will ensure utilization of all trained manpower throughout the country regardless of the site of their original training program. Those squadsmen who successfully completed EMT training in another state outside of the Commonwealth should be allowed to serve their community if they take residence in Virginia.

A national agency for accrediting the EMT, the National Registry of Emergency Medical Technicians, P. O. Box 29233, 1395 East Dublin-Granville Road, Columbus, Ohio 43229, has been established. Registry in this organization is dependent on the applicant passing a written examination furnished and graded by the Registry and a practical examination that adheres to their guidelines. In our recent class, 27 of the 37 elected to take this examination. Twenty-five of the 27 students who successfully passed our examination succeeded in being accredited by the National Registry. These results suggest that the tests are comparable and provide meaningful data on the performance of EMT's. This National Registry test can now be taken in lieu of the state examination for EMT certification.

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A Review of Facial Fractures, 1971-1974

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Maxillo-facial fractures in 358 patients are reviewed, and a significant decrease in the number of patients treated in 1974 is found.

A total of 358 maxillo-facial fracture patients came to the Medical College of Virginia Hospitals between January 1, 1971, and December 31, 1974. This excludes the simple nasal fractures treated on an outpatient basis and fractures not treated surgically for various reasons. All cases included in this study appeared in the monthly MCV operating room records. These do not include less complicated fractures, particularly mandibular and nasal fractures treated in the outpatient clinics. Also excluded are fractures treated by MCV faculty in outlying hospitals. Because of the severity of the injuries, the presence of multiple system injuries, the frequency of litigation, and the patient poverty, an unusually disproportionate number of facial fracture patients were treated at the MCV Hospitals compared to the number treated at other hospitals in the area.

All patients included in this study were treated on an inpatient basis. The managing services were otolaryngology, plastic surgery, oral surgery, ophthalmology, neurosurgery, or any combination of these services. Multiple fractures reduced at multiple times by different services added to the confusion of departmental statistics.

The decrease in the number of surgical cases in 1974 is of particular interest. The same surgeons have been involved in the treatment of all these patients, so there is no change in the criteria for surgery; and there is no appreciable information that more facial fracture patients are being treated in other area hospitals.

	YEARS			
SERVICE	1971	1972	1973	1974
PLASTIC	23	28	31	21
ENT	34	32	24	20
ORAL SURG.	39	26	34	20
EYE	4	4	3	2
PLASTIC/ORAL SURG.	-	2	5	3
ENT/ORAL SURG.	3	3	3	-
NEUROSURG./ENT	1	-	-	-
TOTALS	104	95	100	66

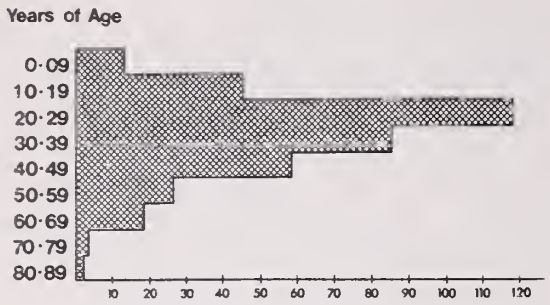
Of particular interest is the relationship between maxillo-facial fractures and motor vehicle travel. Beginning in 1963, when seat belt installation became mandatory on automobiles, a greater number of maxillo-facial injuries were recorded than ever before, since persons using seat belts more often sustain nonfatal injuries and live to receive medical aid. However, the introduction of the 55 mph speed limit in 1974 brought a lessening in the severity of auto accidents, and a corresponding sharp decline in maxillo-facial injuries seen in the MCV Hospitals in 1974 and 1975.[1]

Because of difficulty in obtaining accurate histories, it has often been formidable and even impossible to determine the etiology of the facial injuries. From the hospital records we have been unable to determine the inciting circumstances of the injuries in many of the patients and therefore have been unable to develop any reliable statistics. We feel about one-third of the injuries resulted from vehicle accidents and possibly two-thirds from assault.

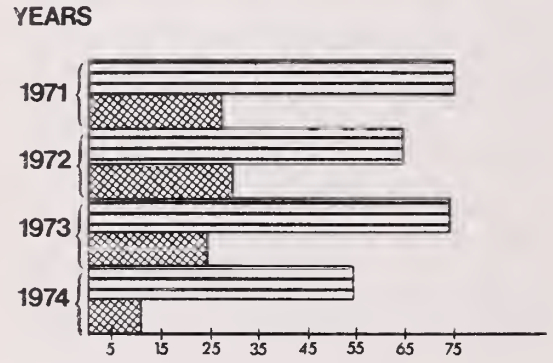
The ages of the patients in this study ranged from 4 years to 79 years, but the peak inci-

From the Department of Otolaryngology, Medical College of Virginia, Richmond.
Submitted 1-29-76.

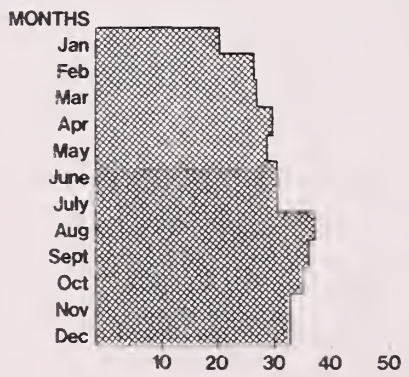
dence is in the third decade of life. One hundred nineteen patients from 20 to 29 years of



age encountered this type of injury, suggesting this is a period of peak activity and mobility in an individual's life. Few injuries of this type are sustained in either the first or the later decades of life.



The incidence of facial fractures in the male sex (lined entries) is consistently higher than in the female sex (cross-hatched entries) in all years reviewed. The sharp drop in the number of females involved in 1974 is unexplainable, unless the decline in vehicular accidents has some bearing, or perhaps the feminist movement suggests that females are now less often assaulted.



The greatest number of facial fractures occurred in August. In Richmond temperatures are frequently above 90° at this time of year, possibly making tempers short, encouraging people to be outside a great deal of the time, and making bodily injuries more common. The injury rate remained high throughout the fall, including the holiday months of November and December. The lowest number of injuries were treated in January and February, possibly the more hazardous driving months of the year. People seem to travel less during this time of year, spending more time indoors and in their homes.

Between 1971 and 1974 mandibular fractures were the most common type of facial fracture treated at the MCV Hospitals. The mandible is predisposed to frequent injury because of its prominence and position. Mandibular fractures are twice as common as fractures of the other facial bones, with the exception of the nose.[2] A significant decrease in the number of mandibular fractures occurred in 1974, associated with a significant decrease in the total number of maxillo-facial fracture patients treated.

Type of Fracture	Year & Number of Cases			
	1971	1972	1973	1974
Mandible	37	27	30	19
Zygoma	26	25	23	11
Zygomatic Arch	3	8	8	5
Blow - Out	12	13	17	13
Compound Nasal	1	4	7	8
Nasa-Fronta-Ethmaid	3	3	1	1
Frontal Sinus	1	2	2	1
Lefort I & II	9	7	8	4
Lefort I & II & Zygoma	8	2	2	2
Lefort I & II & Mandible	4	4	2	2
TOTAL 365	104	95	100	66

Between 1971 and 1974 a relative decrease occurred in the number of fractured zygomas reduced. Blow-out fractures of the orbit have

remained more or less constant in number during the four years studied. The number of compound nasal fractures has progressively increased. Hemorrhage as a complication of facial fractures, particularly naso-fronto-ethmoid complex fractures, has been discussed elsewhere.[3]

The decrease in facial fractures is significant and seems to have extended throughout 1975, although we have not yet tallied our 1975 records. Nevertheless, the number of fracture patients presenting for treatment remains significant.

Acknowledgment

The authors gratefully acknowledge the assistance of Mrs. Rachel Bucher Kauffman in the preparation of this manuscript.

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(For editorial comment on plastic surgery, see page 297.)

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Case Report . . . .

Relief of Allachaesthesia by Commissural Myelotomy of the Lumbrosacral Cord

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In spite of the recent development in new techniques, the neurosurgical treatment of intractable pain remains a perplexing and, at times, a very frustrating problem. Several years ago the author heard the very studious and astute Dr. Henry Wycis admit to the fact that he was just about as much in the dark as to the neuroanatomical and neurophysiological basis of pain as he had been at the beginning of his long and illustrious career as a clinical neurosurgeon and neurophysiologist. As of this date, I am sure that this opinion is still shared by the majority. This report is presented to try and clarify only a small portion of the mechanisms operating in the interesting perception that we label as pain.

The phenomenon of allachaesthesia, or the distant referral of sensation to other parts of the body from an analgesic area, was first observed by the author in a patient who had an analgesic right leg following anterolateral cordotomy for cancer involving its innervation. Later, in his postoperative course, he developed excruciating pain in the opposite thigh. The left thigh was then appropriately xrayed in hopes of finding a pathological fracture to explain this unfortunate man's distress. Much to our surprise, we discovered no local pathology. It was not until an astute nurse had noticed that movement of the right, or analgesic, thigh had caused the patient literally to cry out with pain, that we xrayed the right thigh and found a pathological fracture. When the fracture site was properly treated, the patient's discomfort was markedly alleviated in the left thigh. An excellent review of the experiences of others regarding this curious misinterpretation of the origin of sensory stimulation can be found in the book of White and Sweet[10]. The cutaneous dermatomes referred to in this study are those depicted by Keegan and DeJong.[2]

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Submitted 5-20-75.

Case Report

P.P., a 32-year-old Caucasian female, was first seen in March, 1972. She had complained of low back and bilateral leg pain off and on since 1965. By 1968, the pain no longer responded to conservative treatment. The pain then was confined mostly to the left leg. She underwent laminotomies at L4 and L5 with excision of discs at both levels.

In 1969, she again underwent laminotomies at L4 and L5 for pain in both legs, but much more so in the right. The disc was removed at L5 and a neurolysis performed at L4, on the right.

In 1971, she was reexplored, essentially for the same symptoms as she had in 1969, i.e., a right lateral disc syndrome, but with a minor complaint of pain in the left leg. A neurolysis was done at the right L4 and L5 interspaces.

In March, 1972, she underwent dorsal root rhizotomy at L5 and L4 for right radicular pain. This procedure resulted in a right foot drop, which later subsided, and slight hypalgesia and hypesthesia over an L5 and S1 root distribution, being more pronounced over S1.

Several months later, her pain was as severe as before. On July 11, 1972, she underwent left D3-D4 anterolateral cordotomy for right leg pain. This resulted in a spastic paresis of the left leg with analgesia and thermoanesthesia on the right to D7. The left leg paresis improved considerably so that she could walk unassisted; however, the stigmata of spasticity persisted, with hyperactive DTRs, moderate clonus and a positive Babinski sign.

In October, 1972, she developed severe radicular pain in the left leg. On October 27, she underwent exploration of the left L4 and L5 interspaces with neurolysis and a dorsal rhizotomy at S1. Postoperatively she complained of a shock-like sensation in the left leg when she moved. There was a scattered, barely detectable loss of pain and light touch sensation over a left S1 root distribution. Within a matter of several days, her preoperative left leg pain had returned. It was at this very frustrating point that the following observations were made, precipitated by the pa-

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tient's fear of losing urinary bladder control if she underwent a second cordotomy:

1. Straight leg raising was still positive on the left, with cross reference from right to left as it had been preoperatively.
2. Deep pressure by squeezing, over the anterolateral foreleg on the right from knee to ankle, caused diffuse shooting pain from the left buttock posteriorly to the knee. Deep pressure over the dorsum of the right foot and sole, as well as compression of the right gastrocsoleus muscles, caused a tingling sensation in the left posterior thigh.
3. Pinprick from the midportion of the right anterior thigh to the knee produced tingling in the left posterior thigh. Pinprick over the right posterolateral thigh and anterolateral foreleg to the ankle caused a diffuse shooting pain from the left buttock to the knee posteriorly.
4. Pinprick over the dorsum and sole of the right foot and medial calf caused a tingling sensation to radiate from the left buttock to the knee posteriorly.

Convinced that the patient had an allachaesthesia and that perhaps most, if not all, of the pain in the left leg actually was arising from the analgesic right leg, the operation of lumbosacral commissural myelotomy was proposed to her to relieve her pain, as well as to spare her urinary bladder control. This decision was based in part on the work of Wertheimer et al,[3,5,7,8] in which they report favorable results in the relief of pain due to pelvic cancer by the use of this procedure, without loss of bladder function. In addition, the postulation of Ray and Wolff[6] is that allachaesthesia was due to a collateral arising from Lissauer's tract, in the analgesic side, synapsing with an ipsilateral interneurone in the dorsal horn, which in turn sends its axon via the posterior commissure to the opposite dorsal horn, where it arborizes to connect with a neurone. The latter neurone, conducting pain sensation, sends its axon via the anterior commissure to ascend the cord in the lateral spinothalamic tract on the side of entry of the noxious impulses (E′E″). We informed the patient that she would lose, to some degree at least, three modalities of sensation in the left leg. These were pain, temperature, and light touch, the latter due to the decussation of touch fibers in the anterior commissure to ascend the cord as the ventral spinothalamic tract.

This lady accepted the procedure at face value with hope, but no guarantee. On November 15, 1972, she underwent surgery for the seventh time for relief of her distressing disability.

A full laminectomy centering over the 12th dorsal vertebra was extended superiorly and inferiorly to expose the whole of the lumbosacral cord. The anterior rootlets on the left side were identified and grasped with a nerve hook individually. Each was stimulated with threshold voltage, beginning with the most superior root, extending inferiorly until the root was encountered which gave rise to dorsiflexion of the left foot. The posterior median septum of the cord was identified by a longitudinal vein which had to be coagulated, divided, and stripped from the underlying pia. Under magnification, the pia was incised for a distance of 1.5 cm below and 1 cm above the level of entrance of the anterior root used as a guideline. The flat tapered eyed end of an ordinary wound probe had been marked at 6mm from the point. This distance of penetration had been previously determined on cadaver cord as necessary to sever both the anterior and posterior commissures. The probe was inserted into the posterior median septum to the depth of 6mm as vertically as possible, in order to prevent injury to any structure bordering either the posterior septum or the anterior median fissure containing the anterior spinal artery and its branches. A longitudinal incision was made in the cord over a distance of 2.5 cm, 1.5 cm below and 1 cm above the anterior root which had caused dorsiflexion of the left foot. There was no bleeding.

Postoperatively, she complained only of incisional pain and a feeling of numbness in the left leg. She had a good bilateral anal reflex and voided without difficulty on the sixth day. However, all was not well, for she had a marked increase in the paresis of her left leg. The weakness was both proximal and distal and of a flaccid type, except for the persistence of hyperactive deep tendon reflexes, but loss of ankle clonus which she had had prior to surgery. The Babinski reflex was positive. She had lost the cross reference of pain upon extension of the right leg. Pressure, light touch, or pinprick over the sole of the right foot now caused only a slight tingling sensation in the left buttock. This later disappeared.

Sensory testing of both legs was carried out on the 8th postoperative day, and again finally on February 19, 1975, a little over two years, three months postoperatively. Vibratory and position sense remained intact on both examinations. On the first examination, dermatomes L3-S2 on left inclusive were tested for pain, temperature, light touch, and light pressure, as well as for the presence or absence of allachaesthesia. Pain loss varied from 30%-100%, the most pronounced being in the L5 and S1 root distributions. Temperature loss varied from 25%-100% greatest from L5 and including S2. Light touch loss on left varied from hyperpathia L3-L4 to a loss of from 75%-

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90% over L5-S2 inclusive. Light touch on the right leg evidenced loss of from 20% to 90% greatest in S1 and S2 inclusive. Light pressure sensation on the left showed a loss of from 20%-90%, greatest in L5 and S2 dermatomes.

The final sensory examination, on February 19, 1975, revealed the following. The cordotomy level on the right had dropped to L4 to pain, temperature, light touch, and pressure, with the greatest loss in pain and temperature sensations. On the left side, the greatest loss to all modalities (pain, temperature, light touch, and pressure) was greatest over the lateral thigh and calf, distal anterolateral leg above the ankle, and dorsum of left foot and great toe, which was interpreted as an L5 dermatome. The loss to pain and temperature sensation was greatest in this distribution with only a zero to spotty minimal loss in the other dermatomes (L3-S2). Light touch and pressure sensations were reduced in a stocking distribution in both legs below the knees with greatest reductions distally and more so in the left leg.

On this final examination there was no cross reference from right to left on straight leg raising. Deep pressure, by squeezing over the anterolateral foreleg on the right from knee to ankle, did not elicit referred pain to the left leg from the buttock to the knee posteriorly, as preoperatively.

Deep pressure over the dorsum of the right foot and sole, as well as compression of the right gastroc-soleus muscles, failed to cause the preoperative tingling sensation in the left posterior thigh.

Pinprick of the right anterior thigh and posterolateral thigh and anterolateral foreleg to the ankle failed to cause tingling dysesthesia or diffuse shooting pain from the left buttock to the knee posteriorly.

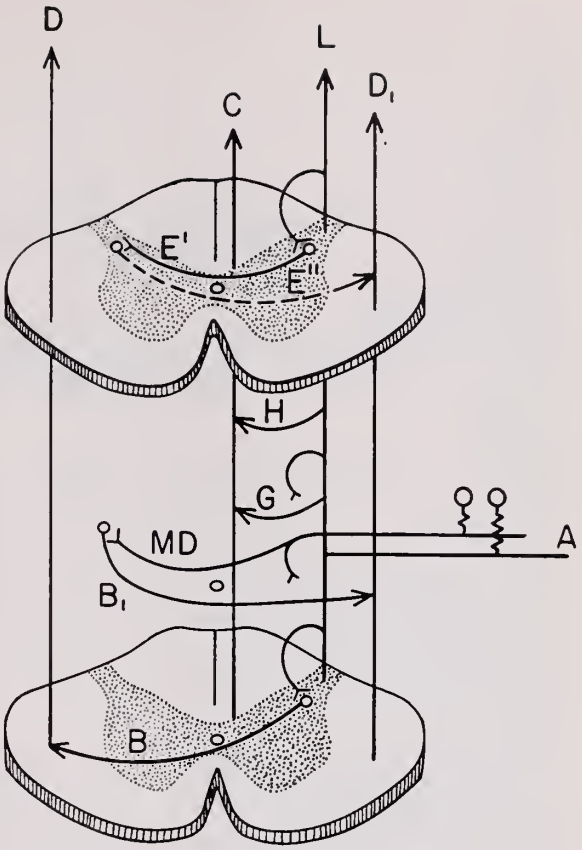
Pinprick over the dorsum and sole of the right foot and medial calf failed to cause tingling dysesthesia from the left buttock to knee posteriorly.

In essence, therefore, this preoperative phenomenom of allachaesthesia would appear to have been abolished permanently by the commissural myelotomy. The spastic paresis of the left leg remains; and, although improved, she wears a below-the-knee prosthesis for foot drop. Radicular pain has returned to the left leg and is quite severe, the relief by myelotomy, therefore, being only transient and lasting only several months, at the most. The right leg has remained pain-free.

Discussion

It is apparent that allachaesthesia can be relieved, more or less permanently, by segmental

commissural myelotomy. The perplexing problems as to how and why remain a mystery. However, two suggestions can be offered. The postulate of Ray and Wolff[6] regarding the existence of decussating physiological pain interneurones in the posterior commissure could be one explanation (E′). However, the existence of a hypothetical interneurone is not necessary; for it is well known, to neuroanatomists, that collaterals from the medial division of the dorsal roots run through the posterior commissure to the opposite side of the cord, where they apparently end in the posterior horn (MD). Another, perhaps more plausible explanation would be the interruption of a physiological, probably neospinothalamic, pain fiber system closely adjacent to the posterior commissure and medial grey matter of the dorsal horns in the posterior funiculi of the spinal cord (G,H,C). The existence of such a system of fibers has been suggested by Wertheimer[9], Sourek,[7] and has been elaborated upon by others[3,4,7]. Injury to this system of fibers might also proffer an explanation as to why, in this particular case, the patient's cordotomy level to pain and temperature in her right leg held at the level of the commissurotomy and dropped no further. Perhaps this observation could be interpreted as a suggestion to do a combined procedure, when undertaking anterolateral cordotomy, to try and insure lasting pain relief in long-term cases. We are all aware of the long-term results of anterolateral cordotomy and the capriciousness of maintaining a good level of analgesia and thermoanesthesia after months or years. A small commissural myelotomy done above the cordotomy site should not cause any additional morbidity and may insure a more effective, longer lasting level of pain relief.[3]



A—Dorsal root and neurone. H—Postulated interneurone or direct collateral from Lissauer's tract to posterior funiculus. B, B_1—Axons to opposite spinothalamic tract. C—Postulated physiological pain fiber posterior funiculus. D—Opposite spinothalamic tract. D_1—Ipsilateral spinothalamic tract. L—Lissauer's tract. E′—Interneurone posterior commissure (Ray). E″—Neurone to D_1 from opposite dorsal horn (Ray). G—Fine fibered collateral from medial dorsal root to C. MD—Collateral in posterior commissure from dorsal root A.

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Cancer Trends . . . .

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Recent Progress in Breast Cancer: The Value of Estrogen Receptor Assays in Predicting Response to Endocrine Therapy

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DURING the last decade, fundamental research into the mechanism of action of the steroid hormones has been extremely enlightening. The broad details of the physiologic mechanism of action of the steroid hormones have been defined. Practical application of this knowledge has greatly enhanced the clinician's ability to predict the response of breast cancer to endocrine manipulation. Continued work in this field promises to expand the usefulness of these methods in the treatment of breast cancer and perhaps extend them to other tumors as well.

Historical Background

The dependence of some breast tumors on estrogen for continued development is well documented. Approximately 35-45% of the younger patients achieve an objective remission following endocrine ablation (usually ovariectomy) while about 40-50% of the postmenopausal patients benefit from adrenalectomy or hypophysectomy.[1]

The affinity of some normal tissues (the "target tissues") for estrogen is well documented. These tissues concentrate and retain estrogen far above the circulating blood levels. As early as 1961, estrogen concentration by breast tumor tissue was also demonstrated after radioactive estrogen was administered to patients.[2] Correlation of the degree of binding to the results of endocrine ablation was less than satisfactory.

More recently, investigators have found the hormone associated with the cytoplasmic and nuclear fractions of the target tissue cells. The specific molecules (called receptors) to which the hormone was bound were separated from calf uteri. The cytoplasmic and nuclear receptors were different when compared by various analytical techniques. Certain hormone-dependent rat mammary tumors were also shown to contain molecules that performed the same function as the uterine receptors described above. In 1966, estrogen receptors were found in the human breast tumors.[3]

Further studies demonstrated that unlike some hormone-dependent tissues, the mammary gland demonstrates a dependence on a number of steroid hormones. Receptors for glucocorticoid,[4] progesterone,[5] and even androgens[6] have been demonstrated in mammary gland and/or human or animal breast tumors.

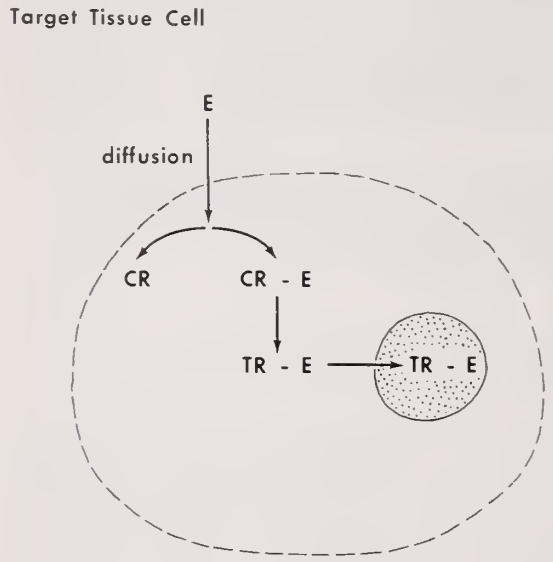
Mechanism of Action of Estrogen

The significant features of the mechanism of estrogen action are common to the mechanisms of virtually all steroid hormones includ-

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ing glucocorticoids, mineralcorticoids, and sex steroids. A schematic representation of the mechanism is shown in Figure 1.



E - Estrogen

CR - Cytoplasmic Receptor

CR - E - Cytoplasmic Receptor - Estrogen Complex

TR - E - Transformed Receptor - Estrogen Complex

Fig. 1.

Estrogen (E) enters the target tissue by simple diffusion. There it undergoes an extremely specific interaction with the cytoplasmic form of the estrogen receptor (CR) to form the cytoplasmic receptor-estrogen complex (CR-E). This cytoplasmic receptor-estrogen complex then undergoes a temperature-dependent transformation to yield what may be called the transformed receptor-estrogen complex (TR-E). The transformed receptor-estrogen complex then is capable of nuclear translocation where it is presumably active in the control of gene expression.

The hallmark of this entire sequence of reactions is specificity. First, the cytoplasmic receptor will only complex with estrogens. Second, the transformed receptor complexes will only enter the nucleus of a target tissue cell. For example, the target tissue cell may be separated into its various fractions and the individual reactions carried out stepwise. If transformed receptor-estrogen complex (TR-E) is incubated with uterine nuclei, the TR-E will enter the nucleus. If liver nuclei are substituted for uterine nuclei, no TR-E will be found in the nuclei.

The above mechanism demonstrates three essential features common to all the steroid mechanisms. First, the cytoplasmic receptor will bind the required steroid with a high degree of specificity. Second, the receptor-steroid complex will undergo a transformation to a form capable of entering the nucleus. And third, the transformed receptor-steroid complex will only enter the nuclei from target tissues. Other functional parameters may vary, but these three remain the same.

Clinical Use of the Estrogen Receptor Assay

It is possible to determine the binding of estrogen to the cytoplasmic receptor *in vitro*. This method has been modified to provide an assay for estrogen receptors in breast cancer specimens.[7]

The essentials of this method are shown in Figure 2. This tissue from the tumor (preferably 0.5—1.0 grams) is shattered at liquid ni-

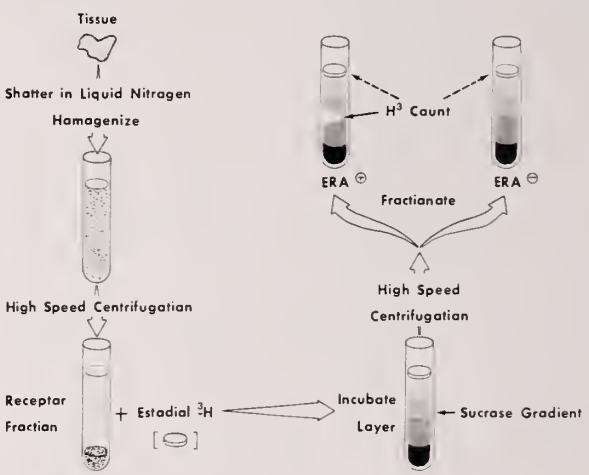


Fig. 2.

trogen temperature. The resulting powder is homogenized and a soluble fraction is obtained by collecting the supernatant of a high speed centrifugation of that homogenate. The cytoplasmic fraction is incubated with tritiated estradiol and layered on top of a sucrose gradient. High speed centrifugation of this gra-

dient for 18-24 hours allows for the separation of the cytoplasmic receptor-estradiol-^{3}H complex from the free estradiol-^{3}H. The gradient is then fractionated and the fractions checked for radioactivity. Appropriate controls are included to insure the binding is truly to the cytoplasmic receptor.

This assay may be performed on tissue from both primary and secondary tumor specimens. The tissue must be frozen promptly without the addition of any fixative. Once frozen, the tissue is stable for weeks.

TABLE I

OBJECTIVE REMISSION OF BREAST TUMORS FOLLOWING ABLATIVE PROCEDURES[1]

	Estrogen Receptor Assay		
Therapy	ER+	ER-	ER±
Adrenalectomy	32/66	4/33	3/8
Castration	25/33	4/53	0/2
Hyphophysectomy	2/8	0/8	-
	59/107 (55%)	8/94 (8.5%)	3/10 (30%)

Roughly 45-50% of the tumors will demonstrate estrogen receptors while 50-55% will be receptor negative.[1] In Table I, the results of endocrine ablations in the different tumor classes are shown. These statistics are a compilation of the results reported to date in the literature.[1] All patient records were reviewed by an extramural panel to judge response. Over 55% of the tumors which are estrogen receptor positive achieved an objective remission following ablative therapy. Only 9% of the estrogen receptor negative tumors showed an objective response following ablative therapy. Clearly, an estrogen receptor negative tumor is very unlikely to respond to estrogen deprivation. Thus, it would appear desirable to spare the patient the time, trauma, and expense associated with this therapy and initiate immediately other modes of therapy.

Since early 1975, our laboratory has analyzed the estrogen receptor content of approximately 100 tumor specimens. Of these 100 specimens, approximately 85% have been primary tumors and the remainder secondary specimens. Between 45-50% of these tumor specimens are estrogen receptor positive. Followup of these patients is currently in progress to determine the results of treatment in those patients who have developed metastatic disease.

Many of the tumor specimens have been submitted by physicians outside the University of Virginia Medical Center. Storage and/or shipment of the tumor specimens in the frozen state has not been associated with any major loss of estrogen receptor content.

Receptors for Other Steroid Hormones in Breast Cancer

It has recently been reported that progesterone receptors have been detected in many breast tumors.[5] It is known from work in non-neoplastic tissues that progesterone receptors are produced as a result of estrogen action. In one small series, estrogen receptor positive tumors that were also progesterone receptor positive had a response rate to ablation of 100%.[8] This is much better than the 50-60% response rate reported in all estrogen receptor positive tumors. Presumably, the absence of progesterone receptors can identify those tumors which have estrogen receptors but in which these receptors are afunctional. If this experience is valid, the increased accuracy of this dual approach assay would be an advance.

TABLE II

OBJECTIVE REMISSION OF BREAST TUMORS FOLLOWING HORMONE ADMINISTRATION[1]

	Estrogen Receptor Assay		
Therapy	ER+	ER-	ER±
Androgen	12/26	2/24	0/1
Estrogen	37/57	5/58	0/2
Glucocorticoid	2/2	-	-
Antiestrogens	8/20	5/27	-
	59/105 (56%)	12/109 (11%)	0/3 (0%)

Future Areas of Investigation

As well as its usefulness for predicting the response of a breast tumor to estrogen deprivation, the assay for estrogen receptors may be useful in predicting responses to other types of treatment. The treatment which comes

most readily to mind is estrogen or other hormone administration to the postmenopausal patient. In Table II, some hormone treatment results have been correlated with the estrogen receptor assay results.[1]

As more tumors are subjected to this assay, it would appear desirable to correlate the results of the estrogen receptor assay with clinical parameters such as prognosis, length of survival, and response to various treatment modalities. The usefulness of these might be further enhanced by obtaining complete hormone receptor profiles for the tumor.

While the areas mentioned above are still far from yielding conclusive data, they hold significant promise for adding to the clinician's arsenal of weapons in attacking this common cancer. In addition, this entire line of investigation again emphasizes the major role basic research plays in the discovery and application of new techniques to clinical problems. Less than a decade ago, conclusive evidence of specific cytoplasmic receptors for steroid hormones had not yet been obtained. Yet today, this area of investigation may be one of the most significant advances in cancer therapy of the last 10 years.

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COMMENT

Dr. Panko has given us a concise overview of the progress made in breast cancer receptor analysis. It is clearly apparent that a negative result gives the clinician more guidance than a positive test. If the respective tumor does *not* contain estrogen receptor, then alteration of the hormonal milieu by either additive or ablative endocrine manipulation will benefit less than 10% of these patients. Consequently, chemotherapy should be instigated as the treatment of choice for systemic metastatic disease under these circumstances. (Multiple-drug chemotherapy may now expect to benefit 50-60% of these patients.)

The presence of estrogen receptor activity is not synonymous with hormone dependence. As shown in Table I, only 55% of the pa-

tients with this activity have hormone dependent tumors in terms of responsiveness to endocrine measure. The clinician is obliged to correlate the patient's age, menopausal status, site of metastasis and disease-free interval with this added laboratory information before subjecting the patient to endocrine manipulation. One cannot rely upon positive estrogen receptor activity alone to dictate therapy. Current laboratory investigations of other receptors which bind with progesterone, prolactin, and the androgen hopefully will increase the predictability of determining hormone dependence.

This assay can only be valid if the specimen is of adequate size and is properly quick frozen, stored, and transported. Inadequate freezing or thawing will result in a negative ER assay which may give misleading information to the clinician making therapeutic decisions.

Our procedure at MCV is as follows:

> Ideally the specimen should measure approximately 1 cm. As much fat, fibrous tissue and skin as possible is debrided. While frozen section confirmation of diagnosis is being performed, the tumor for analysis is kept on ice. The tissue should then reach the laboratory within 30 minutes and is quick-frozen.

Liquid nitrogen freezing is optimal; however, most community hospitals do not keep this in stock. An alternative is to use the fluorohydrocarbon aerosal spray—"Cryo-Kwik"—manufactured by Damon-IEC Division. This will quick-freeze the tissue to −20° C in 30 seconds or less. The tissue is then stored at −70°C. We have performed this assay in tissue stored for longer than six months without loss of activity, so there is no immediate rush in transporting the tissue to the laboratory for assay. When transporting, however, the frozen tissue must not be allowed to thaw and must be shipped on dry ice for this reason.

We feel that ER should be performed on cancer tissue from all patients with breast cancer at the time of initial treatment if this is feasible. A significant number of patients who undergo potentially curable mastectomy will eventually develop recurrence, and tissue for assay may not be available at the later time that this information is desired. If metastasis occurs in the lungs, bones, or viscera, frequently a biopsy for ER cannot be conveniently performed. Despite the limited information we now obtain from this approach, it is a first step in this new and developing assay approach that will hopefully refine our therapy for metastatic breast cancer.

Peter W. Brown, M.D.
Assistant Professor of Surgery
Division of Surgical Oncology
Medical College of Virginia



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Portsmouth Physicians Will Lead Virginia's Big Fall Meeting

The Portsmouth Medical Society will be host to the 1976 Annual Meeting at the Williamsburg Conference Center November 4 to 7. Dr. Arthur A. Kirk has been named chairman of arrangements, with Dr. J. S. Garrison III as his vice-chairman. Dr. Emil S. Sayegh is president of the Portsmouth Society.

These Portsmouth physicians are chairing committees: Dr. John W. Hollowell, hotels and halls; Dr. Harry D. Cox, entertainment; Dr. Gerald Weitzman, scientific exhibits; Dr. C. M. G. Buttery, press and publicity; Dr. Harvey J. Breit, golf, assisted by Dr. Thomas H. Webb; Dr. Ronald L. King, tennis, assisted by Dr. Edward B. Ostroff and Dr. Fay I. Carr, Jr. Mrs. Gerald Weitzman leads the Woman's Auxiliary plans.

Three Portsmouth members are exploring added attractions for this meeting. Dr. A. A. Ruiz is researching a display of hobbies; Dr. Sayegh is formulating possible sight seeing tours; and Dr. James Vincent Scutero is looking into the feasibility of a bridge tourney.

Portsmouth is 45 miles from Williamsburg, an additional burden for these hospitable men.

28th ANNUAL WORKSHOPS AND SCIENTIFIC PROGRAM of the SOCIETY FOR CLINICAL AND EXPERIMENTAL HYPNOSIS.

June 26-30, 1976. Sponsored by the University of Pennsylvania (Philadelphia, PA). Basic and advanced workshops in the use of hypnosis in medicine, psychotherapy, dentistry, and research will be offered. Further special workshops will be offered in the use of hypnosis with children, as well as self hypnosis and the control of pain. For registration and a more detailed description of the various workshops offered, as well as information regarding the scientific meetings, please write to Martin T. Orne, M.D., Ph.D., The Institute of Pennsylvania Hospital, 111 North 49th Street, Philadelphia, PA 19139.

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- For program and registration form, please contact Mrs. Susan Weiss, 13407 Brackley Terrace, Silver Spring MD 20904.

Calendar of Medical Events, 1976

April

Annual Clinical Conference—Sponsored by Louise Obici Memorial Hospital—National Guard Armory, Suffolk—April 14.

Current Concepts of Clinical Infectious Diseases—Sponsored by American College of Physicians in conjunction with University of Virginia School of Medicine—Charlottesville—April 21-23.

Symposium on Musculoskeletal Pain Syndromes—Sponsored by The Fairfax Hospital—The Fairfax Hospital, Fairfax—April 24.

Annual Joint Cardiac Symposium—Sponsored by the Heart Association of Northern Virginia—Arlington—April 21.

Medico Legal Workshop—Sponsored by Office of Chief Medical Examiner, MCV Department of Legal Medicine, Virginia Society for Pathology, Inc. and Virginia Academy of Family Physicians—Virginia Baptist Hospital, Lynchburg—April 22.

Pediatric Day—The Sutton Lectureship—Sponsored by Department of Pediatrics, MCV—Hyatt House, Richmond—April 22-24.

Practical Advances in Medicine—MCH 9th Annual Symposium—Sponsored by Medical Center Hospitals and Eastern Virginia Medical School—Omni International Hotel, Norfolk—April 26-27.

Annual Meeting—Medical and Chirurgical Faculty of Maryland—Hunt Valley Inn—Hunt Valley, Maryland—April 28-30.

Swineford Allergy Conference—Sponsored by the Department of Medicine, University of Virginia, Charlottesville—April 30.

Virginia Surgical Society—Annual Meeting—The Homestead—Hot Springs—April 30-May 1.

May

Virginia Allergy Society—Annual Meeting—University of Virginia, Charlottesville—May 1

Annual Assembly—Virginia Academy of Family Physicians—Hyatt House—Richmond—May 5-9.

Suffering and Pain: Modern Challenges to Medicine, Health Care and Theology—3rd Annual Symposium sponsored by the Chaplains of the Naval Hospital, Portsmouth, and The Medical Society of Virginia Committee on Medicine and Religion—Hospital Building 215—May 6.

Recent Advances in Endocrinology—Sponsored by American Academy of Pediatrics—McKim Conference Room, University of Virginia, Charlottesville—May 6-8.

Practical Internal Medicine—Advances and Review—Sponsored by American College of Physicians in conjunction with University of Maryland School of Medicine and Baltimore Veterans Administration Hospital—Hilton Inn, Annapolis, Maryland—May 10-12.

EEG Symposium—Sponsored by Department of Neurology, MCV—Richmond—May 17-18.

Annual Spring Forum for Child Psychiatry—Sponsored by Division of Child Psychiatry, MCV, and Virginia Treatment Center for Children—Richmond—May 21.

Clinical Rheumatology for the Practicing Physician—Sponsored by the Virginia Chapter of the Arthritis Foundation, Virginia Regional Medical Program, Medical College of Virginia, University of Virginia School of Medicine, and Eastern Virginia Medical School—Bonhomme Richard Inn, Williamsburg—May 21-22.

Annual Clinical Session—The Virginia Society of Ophthalmology and Otolaryngology—Williamsburg Conference Center—May 26-29.

The 3rd Symposium on Common Pediatric Problems—Sponsored by George Washington University and the Children's Hospital National Medical Center, Washington—Washington—May 27-29.



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- Donald P. King, M.D.
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Editorial....

A Presentation of Ways and Means

GRANTED that the major purposes of the *Virginia Medical Monthly* can be summarized under these four general categories:

- To serve as the official publication of The Medical Society of Virginia and thereby to be the prime means of communication between the Society and its members, as well as between each of its members.
- To keep the doctors of Virginia abreast of major medical issues, and to promote thoughts concerning medicine, particularly in Virginia.
- To furnish a medium through which our readers can publish scientific papers, and a forum through which they can express themselves about current medical topics—philosophic, socioeconomic, scientific, or whatever.
- To function as an important source of continuing education for our readers.

The next consideration must be that of ways and means of accomplishing these purposes.

One point has to be established at the outset. In addition to the usual standards of accuracy, concision, general interest, and a hoped for excellence, our journal has the constraints of time and space common to all publications. There can be no newspaper type rapid communication, for an irreducible two-week time lag in publication is imposed by the requirements of the printer and the delivery system. And, as many of our essayists are aware, there may be a hiatus of months between the acceptance of the manuscript and its publication because of the strictures of space.

As the official publication of The Medical Society of Virginia, the *Virginia Medical Monthly* will reflect the actions of the Society as accurately and effectively as possible. The pages are open for messages from the President of our society and from other officers. The activities of the Women's Auxiliary will be reported. To the extent that we have them, there will be regular notices about our members' doings, honors, and, unfortunately as well, the obituary column.

Space will be devoted each month to a consideration of broad issues, with emphasis on matters of special concern to Virginia doctors. There have been and will continue to be excellent columns dealing with VaMPAC, with our state agencies, with insurance, and with other matters of major concern. Each issue has had and will continue to have commentaries, special articles and editorials dealing with Professional Standards Review Organizations, the National Health Planning and Resources Development Act, and the operation of the health systems agencies, Regional Medical Programs, national health insurance, and nurse practitioners and physician assistants. The list is really too long to enumerate. Additionally, the medical profession has many interests and responsibilities shared with other professions. We look forward to having articles dealing with philosophical, theological, and ethical matters such as situation ethics, death with dignity, and others.

A determined effort to involve our readers in the issues facing our profession and our society by way of a lively section devoted to Letters to the

Editor should prove to be particularly useful and interesting. From time to time your journal has carried letters, but no regular pattern has been established. We hope that such a section can be established, and we solicit letters dealing with any subject germane to our purposes, including comments on articles published in the *Virginia Medical Monthly*. The letters will be printed as promptly as possible so that they can be as topical as possible. Space limitations require that communications be brief, and they may be subjected to further editing.

It is hoped that clinical observations and techniques which are useful and interesting will be the subject of brief communications or clinical notes. A series of cases, a clinical study, or a laboratory investigation that provides fresh, new concepts or insights into human illness may constitute the basis for an original article.

Each issue of the *Virginia Medical Monthly* will have a section expressly directed toward continuing medical education. We shall solicit, if necessary, state of the art or review articles dealing with current advances and levels of knowledge in one of the major disciplines. It is hoped that our medical schools and other centers of medical education in the state will submit carefully edited records of clinical pathological conferences, departmental rounds, and major lectures at the post graduate level. Abstracts of papers to be presented at state and regional meetings will be welcomed.

All of us who have enjoyed the *Virginia Medical Monthly* and have profited from it through the years recognize at once that nothing new has been advanced by me either in proposing the purposes or in suggesting the means for our journal to pursue them. Dr. Warthen and his staff have experimented with all of the above ideas and have actuated the better ones. Particularly valuable has been the pattern of editorials and guest editorials that characterized the journal under his leadership as Editor, and this must continue. Indeed, the journal will be the poorer if Dr. Warthen does not continue to favor us with wit and wisdom from his present post of Editor Emeritus.

The justification for these two editorials dealing with the course of the *Virginia Medical Monthly* over the next period of years is simply that they have given a new editor the opportunity of thinking with pen and paper (as well, I hope, with cerebral cortex) and thus of recording clearly for you, the readers and supporters of this journal, his ideas as to what to do and how to do it. This public recording will also set before our readers and supporters their opportunity and obligation to be active participants in seeking their fullest benefit from the *Virginia Medical Monthly*.

W. T. T.

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For only $17.76 or $19.76 you can become a member of the Bicentennial AMA-ERF Club, this invitation issued by the Woman's Auxiliary on behalf of needy medical students. Your membership check is tax deductible, and you win the gratitude of a young person whose medical studies are jeopardized by insufficient funds. Make your check payable to the AMA-ERF Auxiliary Bicentennial Fund and mail today to Mrs. Randolph H. Hoge, Chairman, Longview, Manakin VA 23103.

Letters to the Editor . . . .

Editor's Note: In a report on page 277, Drs. Frable and Demicali point out the number of services that treat facial fractures at the Medical College of Virginia. Of the 358 patients with maxillo-facial fractures, 103 were treated by the plastic surgery service, 110 by the otolaryngology service, 119 by the oral surgery service, 13 by the ophthalmology service, and the remainder on combined services.

In the following letter, brought to our attention by Dr. W. A. Atiyeh of Richmond, Dr. Trent W. Smith speaks more directly to the overlapping interests of many surgeons, particularly in the plastic and reconstructive areas. Dr. Smith is past president of the American Academy of Facial Plastic and Reconstructive Surgery; his letter first appeared in Postgraduate Medicine, March, 1975. His common sense discussion concludes with the eminently fair statement: "The most important consideration, therefore, is not the surgeon's title but his ability as manifested by his results."

Dr. Smith's letter is reprinted here, even though some of our readers may have seen it, because of its pertinence, in this day of specialization and subspecialization, and the implications that such may have on assignment of patients, hospital privileges, Board certification, fees, and, even, malpractice suits. We welcome additional comments from our readers. *W. T. T.*

At a time when federal agencies and hospitals are especially concerned with definitions, privileges, and capabilities, it behooves an enlightened medical profession to reflect on who's who in the growing field of plastic surgery. We tend to rely on semantics and impressions. If plastic surgery is needed, we may turn to a plastic surgeon because he is a specialist. That tendency is fine, but in following it, we fail to recognize the many practitioners of plastic surgery who do not use the title "plastic surgeon."

Basically, plastic surgery is both a method and a medical specialty. In effect, the plastic surgeon is a specialist in the method. He is obviously a practitioner of plastic surgery, is certified by the American Board of Plastic Surgery, and is officially designated a plastic surgeon. There is virtually no chance of anyone misunderstanding his scope of medical practice.

Who, then, are the other practitioners of plastic surgery? They are specialists in a particular region or organ of the body, for example, ophthalmologists, who after certification by the medical board in their specialty, subspecialize in plastic and reconstructive surgery. Thus, during their specialty training, they master both the specialty region and the method of ophthalmic plastic surgery. Some of these specialists have become known as regional plastic surgeons.

Unlike general plastic surgeons, regional plastic surgeons do not present a consistent identity pattern. Some otolaryngologists may practice under the title "head and neck plastic surgeon" or "cosmetic facial surgeon." Other regional specialists may add the term "plastic surgeon" to their specialty title, for example, the ophthalmic plastic surgeon and the dermatologic plastic surgeon. Still others, such as orthopedists, obstetrician-gynecologists, urologists, neurosurgeons, colon and rectal surgeons, and general surgeons, do not usually add the term "plastic" to their specialty title, although they may use plastic and reconstructive surgical techniques.

A leading ophthalmic plastic surgeon estimates that 1,000 ophthalmologists do a significant amount of plastic and reconstructive surgery. The chief of one otolaryngology residency training program estimates that 4,000 otolaryngologists perform regional plastic and reconstructive surgery. A prominent dermatologist estimates that 300 members of his specialty practice plastic surgery.

About 180 maxillofacial surgeons spend all their time doing plastic and reconstructive surgery. Virtually all of the neurosurgeons, estimated at 2,000, perform cranioplasties for skull defects. Most of the 9,200 orthopedists practice plastic and reconstructive surgery, because that in the broadest sense is the nature of their work. Many of the 6,000 urologists do some plastic reconstructive surgery in their specialty area, as do many of the 30,000 general surgeons who apply plastic techniques in repairing hernias, strengthening the abdominal wall, removing tumors and ulcers, working with or operating burn units, and repairing defects with skin grafts.

Conservative estimates from the most pertinent medical specialties suggest that about 22,000 American physicians practice regional plastic surgery. Of that total, more than 7,000 perform plastic and reconstructive surgery in the head and neck area alone. The significance of these numbers is seen when they are compared with the number of specialists, an estimated 1,500, who are designated plastic surgeons.

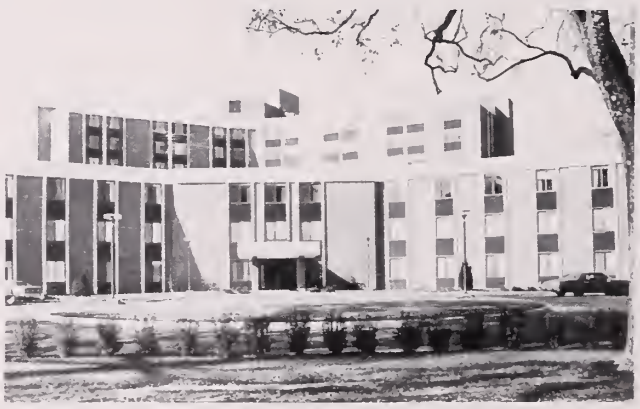
Obviously, no medical specialty has the exclusive capability to perform plastic and reconstructive surgery. No board certification by any specialty and no medical title can guarantee a fine surgical result. In discussing plastic surgery with our patients, we might well remember that there are good, fair, and poor surgeons in all specialties. The most important consideration, therefore, is not the surgeon's title but his ability as manifested by his results.

TRENT W. SMITH, M.D.

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Brochure on Request



Richmond Times-Dispatch

Sunday, July 15, 1973

New Hospital Planned

Plans to build a 66-bed hospital building and to renovate existing facilities have been announced by the Commonwealth Psychiatric Center here.

Work on the new hospital on the center's grounds at 3001 Fifth Ave. is scheduled to start within a few weeks. Completion of the project is expected in late 1974.

Dr. William M. Lordi, director of the center, said the cost of the project including development costs, renovation, site work and the actual construction will be more than $1 million.

Lordi said work on renovating the present facilities has already started.

He said three buildings—the Lee Berg Family Guidance Clinic, Janus Hall and Jacob Silverburg Academy—are to be improved. The renovation will include interior improvements throughout all three, modernization of kitchen and dining rooms and installation of a gym, a workshop and an activity room.

The new hospital building will be a two-story structure with 33 semi-private rooms, six lounges, seven offices for doctors, an examining room, two main nursing stations and a complete dining room.

Plans for the expansion have been approved by the Capital Area Comprehensive Health Planning Council. Lordi said the council is the official health planning authority in the Richmond area.

The expansion is being made to meet a shortage of child and adolescent mental health programs in the Richmond area, Lordi said.

Currently the center has an 18-bed hospital facility.

Lordi said adolescent admissions to mental health centers have almost doubled in the United States in the last 10 years.

Recent surveys have indicated that 10 per cent of all school-aged children are in need of psychiatric help, Lordi said. He said half of these were serious enough to require inhospital care.

The Commonwealth Psychiatric Center is the only one in Virginia devoted almost entirely to child and adolescent mental problems. The center primarily handles children aged 5 to 18, but also cares for adults as outpatients.

Architects for the new hospital building are Lockman Associates of Washington.

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The Medical Society of Virginia . . . .

Minutes of Council

A meeting of the Council of The Medical Society of Virginia was held in Richmond at Howard Johnson's Mid-Town Motor Inn on Wednesday, February 11, 1976.

Members Present: Dr. Raymond S. Brown, Dr. W. Leonard Weyl, Dr. William R. Hill, Dr. Mack I Shanholtz, Dr. W. Taliaferro Thompson, Jr., Dr. William J. Hagood, Jr., Dr. Harold L. Williams, Dr. Charles E. Davis, Jr., Dr. Charles M. Caravati, Jr., Dr. Girard V. Thompson, Sr., Dr. H. C. Alexander, III, Dr. George M. Nipe,, Dr. Harry C. Kuykendall, Dr. James Hal Smith and Dr. C. Barrie Cook.

Others Present: Dr. W. Robert Irby, Second Vice-President; Dr. K. K. Wallace, Jr., Vice-Speaker; Dr. William Stewart Burton, Dr. J. Latane Ware, Dr. Henry M. Snell, Dr. Russell E. Herring, Jr., Dr. William E. Painter, Dr. George E. Broman, Dr. Nicholas G. Colletti, and Dr. Robert V. Gailliot, Vice-Councilors; Dr. William S. Hotchkiss, Dr. Michael A. Puzak and Dr. F. Ashton Carmines, AMA Delegates; Dr. John A. Martin, Dr. Carl E. Stark and Dr. Percy Wootton, Alternate AMA Delegates; Dr. Robert C. Green, Jr., President, Virginia State Board of Medicine; Dr. William S. Allerton, Commissioner, Department of Mental Health and Mental Retardation; Dr. J. W. Craig, Associate Dean, University of Virginia School of Medicine; Dr. D. B. Walthall, III, representing the Dean's Office, Medical College of Virginia; Mrs. Harold L. Williams, President, Woman's Auxiliary to The Medical Society of Virginia; Mr. Edward S. DeBolt, The Reuben H. Donnelley Corporation; Mr. Robert G. Stuart, Executive Secretary, VaMPAC; Mr. William R. Miller, Attorney; and Gary Miller and Mary Beth Taliaferro, Legislative Interns of The Medical Society of Virginia.

Professional Liability

Mr. Edward DeBolt, the Society's special public relations consultant on malpractice legislation, reported on the current status of our legislative package. He stated that, although many letters were being received by legislators, the number from physicians was extremely disappointing. He complimented the Auxiliary on an excellent job, stating that 3,500 letters had been generated thus far through its efforts. He went on to say that the profession must now redouble its efforts and realize that it truly does have a battle on its hands. It must take nothing for granted and must recognize the fact that only a total effort on its part can bring the results it seeks.

Mr. Miller stated that the Insurance Commissioner seemed committed to a joint underwriting association approach and will receive a great deal of support because of the critical situation confronting our Virginia hospitals. He reported that the Senate Courts of Justice Committee had reviewed all of the malpractice legislation and had supported Senator Willey's bills on the ad damnum clause and collateral sources. The Committee, however, will delete the $500,000 limit and that portion of the package having to do with attorneys' fees. It does approve those provisions having to do with the statute of limitations where juveniles are concerned. It would stipulate, however, that it would not apply to the mentally incompetent until guardians have been appointed. The Committee also gave a great deal of attention to those provisions having to do with screening panels and determined that a balanced panel (three plus three) with a Judge presiding would be best. It would also provide that either party can request a panel hearing.

It was brought out that the Society's House of Delegates had insisted on the $500,000 limitation provision and that we must never yield on this particular point.

There was some fear that the Society might be losing its battle and that the membership must be convinced that a crisis situation exists. Dr. Davis moved that Council redouble its efforts to impress physicians over the State with the need of swift and immediate action in view of the crisis situation. The motion also urged that meetings with the membership be held at the District Council level in order to insure local understanding and participation. *The motion was seconded and adopted.*

Mr. DeBolt urged that a flood of mailgrams be generated and that the special brochures available through component societies be distributed quickly and effectively.

Virginia Council on Health and Medical Care

Mr. Arthur S. Brinkley, Jr., President, Virginia Council on Health and Medical Care, reviewed the progress made by the Council since its inception over thirty years ago. He pointed out that there are ten physicians on its Board of Directors and that it works very closely with The

Medical Society of Virginia on all of its projects. Mr. Brinkley indicated that 1,311 physicians used the services of the Council last year—as did 500 communities and institutions. Its career program was carried into 224 high schools with a total of 53,000 students.

Of particular interest was the fact that the Council has neither sought nor received one penny of Federal money. It depends entirely upon contributions from foundations, corporations, individuals, etc. Its current budget is in excess of $188,000 and it must constantly seek new sources of income.

Mr. Brinkley indicated that while the Virginia Hospital Association contributes $30,000 a year towards the Council's career program, medicine contributes only about $23,000. Included in this amount is a $5,000 contribution from The Medical Society of Virginia. Only 470 physicians in the State made individual contributions last year —a matter of both disappointment and concern. Council was requested to consider the possibility of increasing the Society's annual contribution and also finding ways and means of increasing the number of individual contributors.

Dr. Weyl then moved that the Society express its appreciation to the Virginia Council on Health and Medical Care for the great service it is providing all Virginians and urge the support of all physicians. *The motion was seconded and carried.*

Arbitration

An arbitration plan currently being used in the State of New York has aroused a great deal of interest over the Nation. Dr. Hotchkiss reported that, in his opinion, it represents one of the most significant advances in the control of professional liability. It is a voluntary binding type plan that has certain definite advantages. It assures prompt settlement of claims, results in lower administrative costs, eliminates a split of any settlement with counsel, and is nonappealable. The American Arbitration Association is the medium used in New York and insurance carriers seem to like the way it operates. Dr. Hitchkiss stressed that this is not a mediation plan. He added that the awards under the plan generally do not seem as large as those resulting from jury action. He expressed the hope that a similar provision in our legislative package will survive the legislative process and be enacted.

VaMPAC

Council was advised that the VaMPAC Board of Directors had submitted the following five nominations for election to the Board:

6th: Edward J. Stoll, M.D., Lynchburg
7th: James R. Sease, M.D., Harrisonburg
8th: Albert T. Ventzek, M.D., Fairfax
1st: Mrs. Harold L. Williams, Newport News
6th: Mrs. William N. Gordge, Roanoke

A motion by Dr. Alexander to elect the five nominees was seconded and adopted.

Report of Speaker

Dr. Hagood reported that nearly all of the House-passed directives have been carried out. He stated that a special questionnaire had been sent all members of the House and that 41% had replied. The responses are most interesting and will be reported in the *Virginia Medical Monthly*. Dr. Hagood went on to say that no new Rules of Procedure appear necessary at this time.

General Assembly

Dr. Kuykendall stated that, as a result of the great amount of health legislation considered by the General Assembly, it is becoming more and more important for members of the Society to testify before various Committees. Many of them are asked to come to Richmond on extremely short notice and often do so at great personal sacrifice.

Dr. Kuykendall went on to suggest that the Society seriously consider compensating these physician witnesses. Following considerable discussion as to the advisability of such action, Dr. Kuykendall moved that the Society provide realistic compensation for those physicians testifying before Legislative Committees on behalf of the Society. His motion was seconded.

Some concern was voiced over the expense that might be involved and a suggestion was made that travel expenses incurred by the physician be paid. The thought was expressed that most physicians want to serve the Society and do their part. It was agreed, however, that some way to show the Society's appreciation must be found.

Council then agreed with Dr. Hagood that the matter be referred to the Long Range Planning Committee for consideration.

Nurse Practitioner

There has emerged in recent months an indication of conflict and misunderstanding between the roles of the primary physician and nurse practitioner in the community. Dr. Alexander reported on a particular situation in the Southwestern part of the State involving a nurse practitioner and a physician assigned to the area by the National Health Service Corps. He stated that, although the physician had come to the

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3rd, Douglas E. Pierce, M.D., Roanoke

Executive Vice-President: Robert I. Howard, Richmond

State Commissioner of Health: Mack I. Shanholtz, M.D., Richmond

Editor Emeritus, Virginia Medical Monthly: Harry J. Warthen, M.D., Richmond

Speaker of the House: William J. Hagood, Jr., M.D., Clover

Vice-Speaker: K. K. Wallace, Jr., M.D., Virginia Beach

COUNCILORS	(District)	VICE-COUNCILORS
Harold L. Williams, M.D., Newport News	1st	William Stewart Burton, M.D., Nassawadox
Charles E. Davis, Jr., M.D., Norfolk	2nd	James Sidney Kitterman, M.D., Norfolk
Charles M. Caravati, Jr., Richmond	3rd	J. Latane Ware, Richmond
Gordon G. Birdsong, M.D., Franklin	4th	Henry M. Snell, M.D., Petersburg
Girard V. Thompson, Sr., M.D., Chatham	5th	Russell E. Herring, Jr., M.D., Martinsville
H. C. Alexander III, M.D., Roanoke	6th	William E. Painter, M.D., Lynchburg
George M. Nipe, M.D., Harrisonburg	7th	George E. Broman, Jr., M.D., Culpeper
Harry C. Kuykendall, M.D., Alexandria	8th	Nicholas G. Colletti, M.D., Woodbridge
James Hal Smith, M.D., Christiansburg	9th	Robert V. Gailliot, Marion
C. Barrie Cook, M.D., Falls Church	10th	Richard L. Fields, M.D., Fairfax

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates	*Alternates*
1975-1977	1975-1977
William S. Hotchkiss, M.D., Norfolk	John A. Martin, M.D., Roanoke
Michael A. Puzak, M.D., Arlington	Carl E. Stark, M.D., Wytheville
1975-1976	1975-1976
F. Ashton Carmines, M.D., Newport News	Percy Wootton, M.D., Richmond

area hoping to remain after his tour of duty had been completed, he was now having second thoughts because of the situation which exists. The physician finds himself in competition with the nurse practitioner and the situation has caused a definite rift in the community.

Dr. Alexander expressed the opinion that the time had come for some general principles and policies to be established. He was particularly interested in determining what relationship should exist between nurse and physician—particularly when there is no official connection between the two. He also raised the question as to what level of care the nurse practitioner should represent and how her presence on the scene affects the overall practice of medicine. He also raised the question of supervision—particularly the sequence and time factors involved.

Dr. Shanholtz stated that a unique situation exists in the County concerned and that he would be reluctant to see the nurse practitioner removed as long as there is any doubt as to whether the physician will definitely stay on.

Dr. Robert Green, President of the State Board of Medicine, reported that he was quite aware of the situation and that the Board of Nursing had been requested to conduct a hearing. During the ensuing discussion it was mentioned that the nurse practitioner holds regular office hours, makes certain drugs available, conducts certain laboratory tests (urinalysis, etc.), and has been providing a basic type of service.

Dr. Alexander again stressed the importance of the "relationship" and "supervision" factors and moved that the matter be reviewed by an appropriate Committee of the Society in consultation with representatives of the State Board of Medicine and State Department of Health. Its findings and recommendations would be reported back to Council. *The motion was seconded and adopted.*

Continuing Education

The House of Delegates, during its meeting in Roanoke, directed that Council should consider any bill introduced in the General Assem-

bly relating continuing education to licensure. Since such legislation has been introduced, Council was requested to determine the Society's position.

Dr. Green stated that the Board is quite pleased with the Society's position on continuing medical education and membership. He indicated, however, that the Board is quite concerned about those physicians who are not members of the Society. Experience over the years has convinced the Board that something must be done to insure competence and effective discipline. Consequently, House Bill 191 is before the General Assembly and contains, to the maximum extent possible, suggestions made by members of the Society. These include a start up date in 1978 in order that the program under the direction of the Society's Committee on Continuing Medical Education can first be placed on a sound operational footing. Dr. Green advised Council that the Office of the Attorney General had confirmed the fact that members of The Medical Society of Virginia cannot be excluded from such legislation.

Dr. Green went on to state that the proposed legislation is a reflection of concern for all physicians and that he hopes very much that the Society will lend its support. If outright support should not be forthcoming, he requested that the Society take a neutral stand.

Dr. Hagood reviewed the action taken by the House of Delegates and called attention to the fact that an amendment to the By-Laws must be adopted before the intent of the resolution relating continuing education to membership can be carried out.

Dr. Davis stated that only eight states have thus far taken action relating continuing education to licensure and that he questions the urgency at this particular time.

Dr. Weyl was of the opinion that the bill in question could not pass without Society support and moved that The Medical Society of Virginia maintain its opposition. The motion was seconded.

Dr. Kuykendall stated that he still believes that any legislation should clearly recognize the work being carried on by the Society and should not be implemented until the Society program is fully operational.

A question was raised concerning the eventual cost of a full fledged program of continuing education in Virginia and it was brought out that the legislation sponsored by the Board would provide financial assistance.

The motion by Dr. Weyl was then adopted.

Conference of Officers of Component Societies

Council was requested to consider the advisability of sponsoring periodic conferences for officers of component medical societies. The conferences would be for the purpose of improving communications—a need which many believe has existed for some time. The cost factor was discussed and it was estimated that the cost of such a conference would run somewhere between $600-$1,000.

Dr. Weyl pointed out that better and more frequent use could and should be made of the District Councils and called attention to Article X, Section 8 of the By-Laws.

A motion by Dr. Cook to refer the matter to the Long Range Planning Committee for further consideration was seconded and adopted.

AMA Meeting in Dallas

Council was pleased to learn that the chorus of the Auxiliary to the Roanoke Academy of Medicine would participate in the inauguration ceremonies when Dr. Palmer is installed as AMA President during the June meeting of that organization in Dallas. It will present a special 25-minute program and its expenses will be borne by AMA.

A question was raised as to whether The Medical Society of Virginia should do anything additionally in honor of the occasion. Several suggestions were received—including a special reception and a hospitality suite separate and distinct from that of the Southeastern States.

Dr. Hagood moved that the Society sponsor a special reception for Dr. Palmer and the Roanoke Auxiliary chorus. *The motion was seconded and adopted.*

Dr. Haley

Dr. Harold B. Haley, Roanoke, was reported to be seriously considering the advisability of seeking election to the AMA Council on Medical Education. He was reported to be well qualified.

A motion was offered by Dr. Davis directing that Dr. Haley's candidacy be supported and that such measures as might be needed to bring about his election be taken. *The motion was seconded and carried.*

AMA Regional Meetings

The AMA Department of Continuing Education Seminars wishes to sponsor another Regional Meeting in Williamsburg during 1977. A number of postgraduate courses would be offered on

(*Continued page 307.*)

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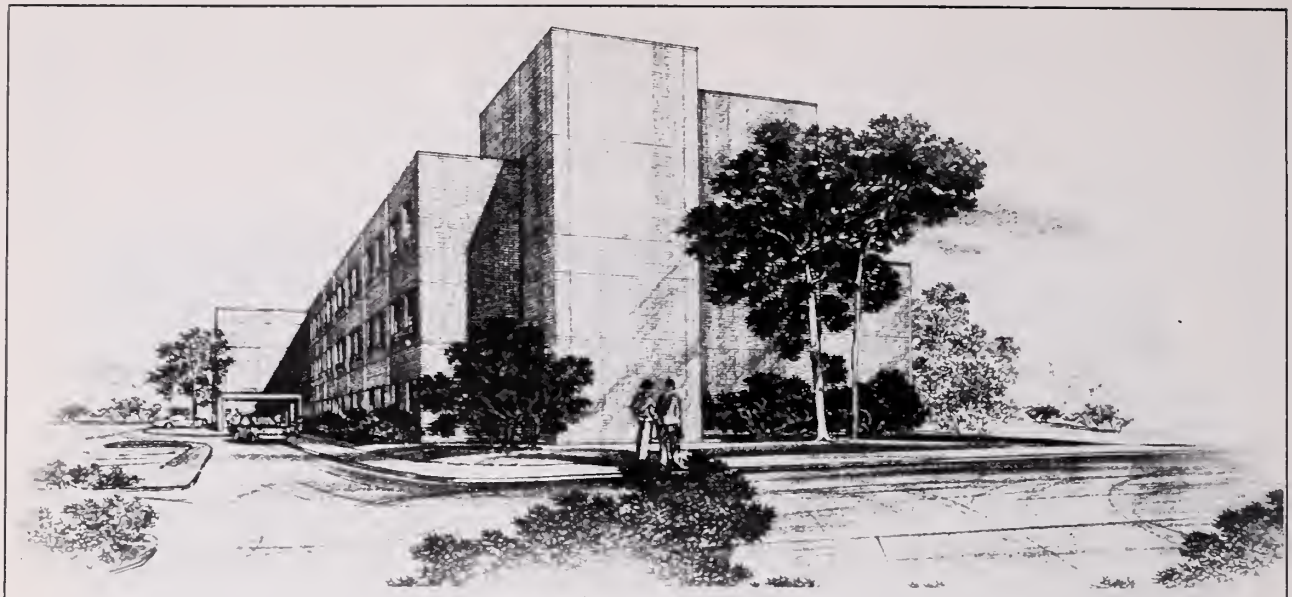
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a Saturday and Sunday and The Medical Society of Virginia, along with our three medical schools, would be listed as co-sponsor. *A motion to approve the Regional Meeting and serve as co-sponsor was seconded and adopted.*

Advertising in Virginia Medical Monthly

Council was advised that, in the past, the Society has rejected any advertising from insurance carriers which would appear to be in competition with our own sponsored programs. Another reason for such rejection was that such advertising might be construed as endorsement of that particular plan. Recently, however, some question has been raised as to whether this policy is fair and proper.

Although there was some difference of opinion on the subject, it was the consensus that the Society should reconsider its policy. Consequently, Dr. Alexander moved that the *Virginia Medical Monthly* accept legitimate advertisements but print a statement that publication should not be construed as endorsement. *The motion was seconded and carried.*

Nonprofessionals

In recent weeks there has been some concern over the fact that carriers are permitting nonprofessionals to challenge and question what seems perfectly obvious to physicians. Dr. Davis stated that, from all indications, some carriers which offer policies providing for the care of private duty nurses are taking steps to avoid payment. He stated that physicians are regularly being questioned with reference to their orders for private duty nurses and that such questions are apparently originating with nonprofessional supervisors.

Dr. Wallace stated that the Professional Relations Committee of Blue Shield of Virginia had recently discussed this very problem and recommended to its Board that the provision for special duty nurses be eliminated from the various contracts. It was the consensus that if such coverage is sold, the physician should not be continually questioned concerning his orders.

It was then moved by Dr. Davis that the Society voice its awareness of problems confronting carriers where private duty nursing coverage is concerned but urged that the orders of attending physicians not be questioned. *The motion was seconded and carried.*

"Miss Hope"

Council was once again asked to consider the advisability of making a financial contribution to the "Miss Hope" program of the American Cancer Society, Virginia Division. The program is designed to stress the hopeful side of cancer through selection of a personable and articulate nurse to represent the Cancer Society at community activities and meetings.

A motion by Dr. Davis to support the program in principle was seconded and adopted.

Medical Audit Seminar

The Colonial Virginia Foundation for Medical Care—the PSRO for Area V—will sponsor an Advance Medical Audit Team Seminar on April 29-30. The Seminar will be held at the Cavalier Hotel, Virginia Beach, and conducted by the Joint Commission on Accreditation of Hospitals. The Society has been asked to endorse the Seminar and lend its name as a co-sponsor. No financial responsibility would be involved.

A motion by Dr. Hill to endorse and co-sponsor the Seminar was seconded and adopted.

Travel Program

Dr. Weyl reported that indications are the one-week trip to Cancun being sponsored by the Society has been well received. Approximately 130 have signed up to leave February 23.

It has been proposed that the Society consider another one-week trip in 1977—this one to Rio de Janeiro. Dr. Weyl indicated that the flight would leave from Dulles and go directly to Rio. He brought the matter up only for the purpose of ascertaining whether or not there was any interest in such an undertaking. It was the consensus that such a trip might very well be considered at the appropriate time.

Legislative Report

Mr. Osburn acquainted Council with the work being performed by the Society's two legislative interns, Miss Mary Beth Taliaferro and Mr. Gary Miller. He indicated that they have contributed a great deal to the increased effectiveness of the overall legislative program. He then discussed HB 190—the Society's legislative package on malpractice. In this connection, he distributed a list of those Subcommittee members who would be considering the bill the following week. It was urged that these particular Subcommittee members be contacted just as quickly as possible and impressed with the seriousness of the problem.

Mr. Osburn went on to review proposed legislation on such subjects as drug formularies, alcoholism, hemophiliacs, the impaired driver, optometry, mentally ill, prescription labeling, profile records, child abuse, drug prices, etc.

Council was advised that Society support is being sought for a proposed risk management



study in cooperation with the Virginia Hospital Association. *A motion to support the study was seconded and adopted.*

Social Security Numbers

A great deal of opposition is being voiced to a plan by HEW to require the use of Social Security numbers on all records collected for PSRO purposes. These numbers would be used for the purpose of identifying both physicians and patients. A strong letter and resolution from the Medical Society of New York were among the expressions of opposition brought to Council's attention. Brought out was the fact that the use of Social Security numbers is also being proposed for the Uniform Hospital Discharge Abstract Implementation Plan.

A motion was then introduced putting the Society on record as opposing the use of Social Security numbers in connection with PSRO and the Uniform Hospital Discharge Abstract Implementation Plan. *The motion was seconded and carried.*

It was directed that the Virginia Hospital Association be advised of Council's action.

Physician Manpower Survey

The Virginia Center for Health Statistics was recently established by the State Department of Health to coordinate the collection of health manpower, health facility and vital statistics needed by national, state and local organizations and agencies. These efforts are partial components of the Cooperative Health Statistics System being developed nationwide by the National Center for Health Statistics. The Virginia Center, with the cooperation of the State Board of Medicine, is planning to use the Board's license renewal process for the annual collection of data on physicians, osteopaths, podiatrists, physical therapists and chiropractors.

The above was presented for informational purposes only and required no action.

Insurance Committee

A meeting of the Insurance Committee was held on February 6 and Council was advised of its findings and recommendations. Dr. Weyl discussed his proposal for the establishment of a special reporting endorsement fund and advised that the Committee had endorsed its concept. The Committee also recommended that it be authorized by Council to explore as expeditiously as possible, acceptable mechanisms and that a poll of the membership be conducted for the purpose of determining how much interest in the project exists over the State. *The Committee's recommendation was approved.*

A question was raised concerning the Society's relationship to the Physicians Underwriting Insurance Company and whether or not it could be endorsed as an acceptable alternative. The pros and cons of endorsement were discussed at length and Dr. Kuykendall moved that Council inform the Physicians Underwriting Insurance Company that The Medical Society of Virginia is not opposed in any way whatever to its operation. The motion was seconded.

Dr. Hagood expressed the feeling that the passage of such a motion might well cause some misunderstanding where members of the House of Delegates are concerned. He reminded Council that the House had passed a resolution on the subject in October which would seem to accomplish the desired purpose. The resolution, as finally passed, placed the Society on record as approving in principle the development of a program of professional liability insurance coverage offered by a Virginia physician owned and controlled company as an alternative insurance program.

Dr. Weyl then offered a substitute motion which would have Council reaffirm the House-passed resolution of last October and advise the Physicians Underwriting Insurance Company of its action. *The substitute motion was seconded and carried.*

The Insurance Committee also recommended that the Society withdraw its sponsorship from

the four retirement programs currently in effect. Its recommendation was based on the fact that many options are now available to the individual physician and professional corporations and that Society-sponsored plans no longer meet a real need.

A question was raised as to whether withdrawal of such sponsorship would in any way hamper the Bank of Virginia-Potomac in performing the duties of corporate trustee of the plans. A motion was made by Dr. Hill that the Bank be consulted on the matter and that its thoughts and recommendations be reported back to Council at its next meeting. *The motion was seconded and adopted.*

Committee on Negotiations

Council was advised that a special Committee on Negotiations held its first meeting on February 4 and discussed its role in view of the House-passed resolution which created it. It plans to hold an early meeting with a representative group of component society Presidents for the purpose of obtaining input in a statement of purpose and development of realistic and acceptable guidelines. A member of the Committee will also attend a four-day Conference on Negotiating to be presented by AMA in April.

School of Optometry

Dr. Davis reported that there exists a definite plan to establish a School of Optometry in the Norfolk area. A great deal of opposition has been expressed to such a move in view of the fact that no real need has thus far been established. A question was raised as to whether Council was in possession of sufficient information to justify action at this time.

A motion by Dr. Davis stating that Council can find no need for a School of Optometry in Virginia at this time was seconded but withdrawn when it was learned that the House of Delegates had taken similar and appropriate action in November, 1974. A resolution passed at that time put the Society on record as opposing any legislation that would broaden the scope of the definition of optometry under the laws of the Commonwealth and also opposing the creation and establishment of a School of Optometry in the State.

A motion reaffirming the November, 1974 action of the House was seconded and adopted.

Dr. W. Nash Thompson

Dr. Cook called Council's attention to the recent resignation of Dr. W. Nash Thompson as Chairman of the Virginia Joint Practice Council. He stated that Dr. Thompson had been an able and dedicated Chairman and had done much to bring about a close working relationship between the medical and nursing professions in Virginia.

A motion to prepare, on behalf of Council, a letter of appreciation of Dr. Thompson's many contributions was seconded and adopted.

MALPRACTICE BILL PASSES

As this issue goes to press, the Virginia General Assembly approved legislation setting a $750,000 limit on medical malpractice awards, to take effect April, 1977. The question of constitutionality of the limit clouded passage of the measure; it was proposed that a test be made promptly, probably through an appeal to the Virginia Supreme Court by the State Insurance Commissioner.

The measure also would establish a malpractice review panel (three doctors, three lawyers, and one judge) to decide a claim's validity. The panel's decision would be admissible evidence in court. It could be a binding arbitration board if both parties agreed.

Earlier, the Assembly approved a bill to create a joint malpractice underwriting association for doctors and hospitals. Insurance companies doing business in Virginia would form a pool to furnish policies to doctors and hospitals having difficulty obtaining it.

HSA

Dr. Martin reminded Council that the Governing Boards of the various HSA's are now in the process of being appointed and that there should be no let down in our efforts to obtain adequate physician representation.

PSRO

The Colonial Virginia Foundation for Medical Care (PSRO for Area V) has indicated in a letter to Blue Shield of Virginia that it believes all patients should be subjected to the same standards of care and review processes. It believes, therefore, that it is appropriate that hospitalized patients, other than those covered by Federally funded programs, be reviewed regarding the necessity, quality, etc. of care received.

The Foundation has invited the Board of Blue Shield of Virginia to hold preliminary discussions concerning the feasibility of having PSRO perform these review activities. Some concern, however, has been expressed over having all hospital admissions reviewed by PSRO and some

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Signature

DATE: _____

NAME: _____

TELEPHONE: _____

ADDRESS: _____

PLEASE INDICATE SPECIALTY: _____ COVERAGE DESIRED:

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members of the Blue Shield Board are anxious to have the thinking of the Society on the subject.

During the ensuing discussion it was brought out that it is of the utmost importance for the various PSRO's to obtain funds from other than Federal sources. Although there were some reservations concerning the PSRO proposal, no strong opposition was voiced. *A motion by Dr. Weyl to receive material on the subject for informational purposes only was seconded and adopted.*

Statewide PSRO

Dr. Martin called attention to a recent amendment to the PSRO law which makes it possible for a state to be authorized one PSRO should it so desire. It was recalled that a number of states had requested such authorization two years ago and had their requests rejected by HEW. HEW must now poll all physicians in the State in order to ascertain the wishes of the majority. It is expected that such a poll will be conducted in Virginia some time around the first of March.

Dr. Martin discussed both sides of the matter, pointing out that five Regional PSRO's are established in Virginia and several have staffs already hard at work.

Council was also reminded that the House of Delegates had, on several occasions, made it clear that it desired one PSRO in Virginia. As a result, the Society had submitted to HEW an application for one PSRO with five Regional Subdivisions. The thought was expressed that the five PSRO's already established might possibly continue their work at the Subdivision level.

The opinion was voiced that Council would seem to have no alternative but to keep faith with the House of Delegates and recommend one PSRO for Virginia. A motion was then offered by Dr. Williams which would urge the membership to vote for one PSRO in the State. *The motion was seconded and adopted.*

Council Retreat

Dr. Hagood moved that the President appoint a special committee for the purpose of developing a proposed agenda for a second Council Retreat and also to consider the advisability of holding such a Retreat. Its recommendations would be considered at a subsequent meeting of Council. *The motion was seconded and carried.*

Next Meeting of Council

It was agreed that the next meeting of Council should be tentatively scheduled for Saturday, May 1. The location will once again be Richmond.

There being no further business, the meeting was adjourned.

Robert I. Howard, *Secretary*

APPROVED:

Raymond S. Brown, M.D., *President*

AAMA Meeting Marks 20th Anniversary

Is your medical assistant a member of the American Association of Medical Assistants? And is she going to attend the annual state convention May 7-9 in Roanoke? If your answer is "yes" to both these questions, you're doing yourself a fine favor, Doctor. For the AAMA's program promotes knowledge of the health care field and the maintenance of smoothly running physicians' offices.

The 1976 state convention, to be held at the Hotel Roanoke, occurs during AAMA's 20th anniversary year. The registration fee of $45 (tax deductible) includes the welcome party, lunch and dinner on Saturday, breakfast on Sunday, and the program of speakers. By all means press a check into your assistant's hand to encourage her to attend. And if she is not yet an AAMA member, encourage her to join by offering to pay her dues.

Mrs. Lucy Johnson is registration chairman of the convention; her address is 127 McClanahan Street, Suite 314, Roanoke VA 24014. Ralph E. Hagan, M.D., Richmond, is chairman of the Advisory Board to the State Society; his assistant, Mrs. Dorothy Sellars, will answer your questions at 804/270-9090. Or reach your county medical society, whose official approval is a requisite to each local AAMA chapter.

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Woman's Auxiliary . . . .

Cultivate Content, Avoid Hollyhocks

MD's Wife is the National publication of the American Medical Association Auxiliary. Its Editor-in-Chief, now in her fifth appointed term, is Mrs. Ludel B. Sauvageot, Akron, Ohio, wife of a cardiologist. Mrs. Sauvageot was the guest speaker last month in Richmond at the annual Board meeting of the Virginia Woman's Auxiliary. Her advice on publicity, excerpted here, can be related to all organizations.

Just what is publicity, anyway? To many publicity chairmen, getting notices of meetings and announcements of speakers in the paper is all that matters. Yet such announcements are usually of no value, unless the program is of community-wide interest.

To some, publicity means a picture of the new president presiding at a tea table, or the annual picture of new officers. These are fine, but heaven forbid that your officers are lined up in a row, looking straight into the camera. These pictures all look the same; only the names in the captions are different. Have these persons doing something—talking casually, looking at a book, anything but lined up like a row of hollyhocks. But keep them close together, and avoid wide expanses of flowered wallpaper in the background. And always send in clear, glossy prints in black and white.

Publicity several notches above such pictures is a news article that lets the public realize that the auxiliary is working to make the community a better place in which to live. Be on the lookout for newsworthy projects that editors can write up as features; usually they will interpret auxiliary programs indirectly.

You are fortunate in Virginia to be given space in the *Virginia Medical Monthly*. Through these columns nonmembers may become interested, if the article is newsy and informative. If you want the doctors to read it, remember they don't care a whit about such trivia as lovely table decorations.

At *MD's Wife*, we try to carry stories of interest to all doctors' wives, whether they are active in the auxiliary or not. Problem-oriented articles with which the reader can identify draw greatest reader response. Letters to the editor discussing our articles interest our readers. Letters poured in recently after we published the story of the alcoholic doctor's wife. Some were sympathetic, some extremely critical that we would publish anything that "hangs our dirty linen on the line." One letter commented: "Surely the public should not think there are wives of doctors who are alcoholics. Shame for printing such a thing."

When planning publicity, think beyond the printed word—consider a speakers' bureau offering personal contacts, visits to projects, radio and TV. Strive for quality, not quantity. Meaningless or mediocre publicity is bad. The content of the publicity, not the amount, is what gets across to the public.

But getting the conventional kind of publicity is not our most important task. As doctors' wives we have a responsibility to organized medicine as well as to our husbands. Individually and as a group, we can help develop favorable attitudes toward medicine. A doctor's wife who knows and understands the philosophies and goals of the best in the health care services is, wherever she goes, the finest kind of publicity.

Roanoke's "Safety Sitters" Course Wins an Award

"Safety Sitters," a course offered teen-agers by the Roanoke Auxiliary, was given an Award of Merit in the 1975 contest of the National Safety Council, Woman's Conference.

More than 277 boys and girls who "babysit" for absent parents have taken the course since it was initiated in 1973. They have learned how to cope wisely with telephone calls and knocks at the door and how to deal with intruders, accidents, and fire. MDs and RNs speak to them on handling medical emergencies, child psychologists provide informed insight, and auxiliary members demonstrate how to feed, bathe, dress, and entertain little children. It's an incisive schooling developing baby sitters of special knowledge and responsibility.

Oriental Rugs



My name is Amir Zinat; I am Iranian. Years ago as a graduate student in the U.S., I noticed the big difference in the price of Orientals in my homeland and here. I have chosen, as my business, to sell these rugs at more reasonable prices. These rugs are selected by natives, are considered good investments and are exchangeable.

When buying Oriental rugs, you can make a better selection if you know something about them.

1. Your home is not a museum; it is a place for your comfort, pleasure and relaxation. When selecting an oriental rug, first evaluate how much you like a particular rug and then consider how it complements your decor.
2. All sizes and colors of Oriental rugs are available, suitable for every room in your home including the bathroom, hallways and steps, and a child's room. The money you are willing to invest in a rug should be relative to the degree of its use and enjoyment. Furnish with rugs first the rooms which are used most often.
3. When you have found several rugs you like, compare their prices. If two similar rugs vary considerably in cost, be sure you do not pay the higher price for very minor differences.
4. Color and design (the balance of different parts of patterns and the proper coordination between border and field) are important considerations in selecting a rug.
5. Do not hesitate in selecting a rug which to some may appear "too loud" or "too strong" since soft colors and simple designs often lose their novelty sooner in the home.
6. Oriental rugs are named after the village or, more often, the region of their origin. The quality of a rug may vary greatly regardless of the name. You should judge a rug by its individual merits (workmanship, wools, use of color and design) and not by its name or signature alone.
7. Some irregularity of shape, color, design and workmanship is acceptable in a handmade oriental rug. However, the discrepancies should not be extreme.
8. Natural silk rugs are expensive and are good investments. Be selective in your choice since some synthetic silk rugs are also available.
9. In antique rugs (50 years and older) age and condition are significant factors in judging the value of a rug. This does not necessarily mean that all older rugs have higher value. If a rug is old, it must be in very good condition, otherwise do not consider purchasing it.

I would be happy to help you learn more about Orientals and assist you in any way in your selection.

Please call **358-1711**

also recommend me to your friends

Thank you

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EDUCATION

A regular school curriculum is followed and academic credit is given. The Hampton Roads Reading Center is located within the hospital and provides special instruction for children with dyslexia and other learning problems.

REHABILITATION

Rehabilitation services include individual counseling, special education, and job training programs.

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Obituary . . . .

Oscar Swineford, Jr., M.D.
Charlottesville

Dr. Oscar Swineford, Jr., allergist of national reputation and greatly beloved by countless friends in Virginia and throughout the country, died February 23 in Charlottesville at 79 years of age.

Throughout his adult life Doctor Swineford was identified with the University of Virginia Medical School. As a student, he graduated in the class of 1926. After completing his house staff training, he continued as a faculty member, progressing through the ranks to a full professorship. He was the first appointed chairman of the University's allergy-arthritis division, serving in that post for 30 years. When he died, he was professor emeritus of internal medicine.

As a young man Doctor Swineford began gathering honors; he was elected to Phi Beta Kappa, Alpha Omega Alpha, Raven, and many other student organizations. During his professional years, his memberships, fellowships, appointments, and offices grew to a long and illustrious list; he was president of the American Academy of Allergy, the Southeastern Allergy Association, and the American Association of Certified Allergists, and he chaired many national committees of influence. He was often honored by invitations to deliver distinguished named lectureships over the country. To all else, Dr. Swineford added his gifts and his industry as a writer, authoring more than 135 contributions to the medical literature and two books, "Asthma and Hay Fever for Students and Physicians," a textbook, and "Asthma, Hay Fever, and Other Allergic Diseases for Victims and Their Families," both published by Charles C. Thomas, Springfield, Illinois.

Dr. Swineford was born and received his early schooling in Richmond. In 1917 he joined the U.S. Naval Reserve and was trained as a pilot for this country's first aircraft carrier.

Dr. Swineford's wife died in 1963. He is survived by a stepdaughter.

Charles Yeatman Griffith, M.D.
Mt. Holly, Virginia

Dr. Charles Yeatman Griffith, general practitioner and member of the Medical Society of Virginia for 50 years, died February 11. Born in 1903, Dr. Yeatman took his medical degree from The Medical College of Virginia. His wife and a son, Dr. Lloyd Tayloe Griffith, survive him.

Robert Henry Detweiler, M.D.
Arlington, Virginia

At the age of 65 years, Dr. Robert Henry Detweiler died on January 27. A pediatrician, Dr. Detweiler was a graduate of the Georgetown University School of Medicine. He had been a member of The Medical Society of Virginia for 50 years.

Eugene Lorenzo Willard, M.D.
Arlington, Virginia

Dr. Eugene Lorenzo Willard, internist, died February 16 in Arlington. He was 66 years of age. Dr. Willard was a member of the Class of 1940, George Washington University School of Medicine. He had been a member of The Medical Society of Virginia 21 years.

Edward Palmore Irving, M.D.
Petersburg, Virginia

At 56 years of age, Dr. Edward Palmore Irving died February 14 in Petersburg. An orthopedic surgeon, Dr. Irving was a graduate of the Washington University School of Medicine, St. Louis, and trained at the Medical College of Virginia, Richmond. He had been a member of The Virginia Medical Society for 25 years.

John William Martin, M.D.
Yorktown, Virginia

At 81 years of age, Dr. John William Martin died January 6 in Yorktown. He was a graduate of the Medical College of Virginia, Richmond, Class of 1916, and had belonged to The Medical Society of Virginia more than 20 years.

Your help in making this listing comprehensive and current will be very much appreciated. Please address news of the deaths of members to the Managing Editor, 4205 Dover Road, Richmond VA 23221.

Medicare Mail . . . .

I have noticed that the charges for my professional services are being reduced. I would like to know what index is being applied towards my charges.

Dr. M.R.

At this time, Medicare's basis for payment is derived from charges made by physicians during calendar year 1974. Medicare B updates its profile and payment levels once a year, generally in July or August. The physician's charge for each specific procedure is arrayed, and the median charge is identified; by regulation, this becomes "customary charge". The prevailing charge is determined by arraying the customary charges developed for individual physicians weighted by the frequency count. Currently, an economic index is applied as a maximum ceiling on levels of payment. The Medicare allowable charge is the lesser of (1) the actual charge made by the physician; (2) his "customary" charge for the service; (3) the area prevailing charge; or (4) the economic index calculated allowance (this is based on 1973 prevailing charge plus 17.9%).

* * * * *

I definitely object to the use of "offset" to recover overpayments made to physicians as outlined in Newsletter 31. I feel you have no legal right to employ this method.

Dr. H.W.

The use of offset is specifically authorized by Medicare regulations issued by the Department of Health, Education and Welfare. When an overpayment to a physician is identified, it has been our policy to write, explain the overpayment, and request reimbursement. Many physicians ignore such correspondence. We would have no occasion to use the offset method if the physician would either refund the overpayment, or, if he disagrees with the amount or the existence of the overpayment, would challenge it by letter.

The decision has been made to use offset because several physicians have failed to respond in any way to our written requests for refund.

* * * * *

Some of my office consultations are referred by other than doctors. For instance, I see patients who are referred by lawyers and insurance carriers. They receive a complete office consultation, history and physical, and report as do those sent in by doctors. . . . I have been billing these as consultations.

Dr. C.K.

Consultations are reimbursable only when requested by the attending physician. Medicare coverage is available for the services you describe as long as they were reasonable and necessary for the diagnosis or treatment of bodily injury or disease. However, the fact that the services were requested by attorneys or insurance carriers would suggest that the services rendered were in connection with a routine exam for other than medical necessity.

* * * * *

Today I received 26 separate Medicare checks representing a postage bill of $3.38. Why can't a single check be issued, or, if multiple checks are issued, why can't they be mailed in a single envelope?

Dr. R.H.

The issuance of a single check for services rendered to several patients is referred to as a "summary check." Only recently has the computerized technique been developed that would permit multi-state Medicare carriers, such as The Travelers, to implement this procedure. The Travelers has instituted this procedure in one office and when it has been tested and found to be satisfactory, we expect to implement the procedure in Virginia.

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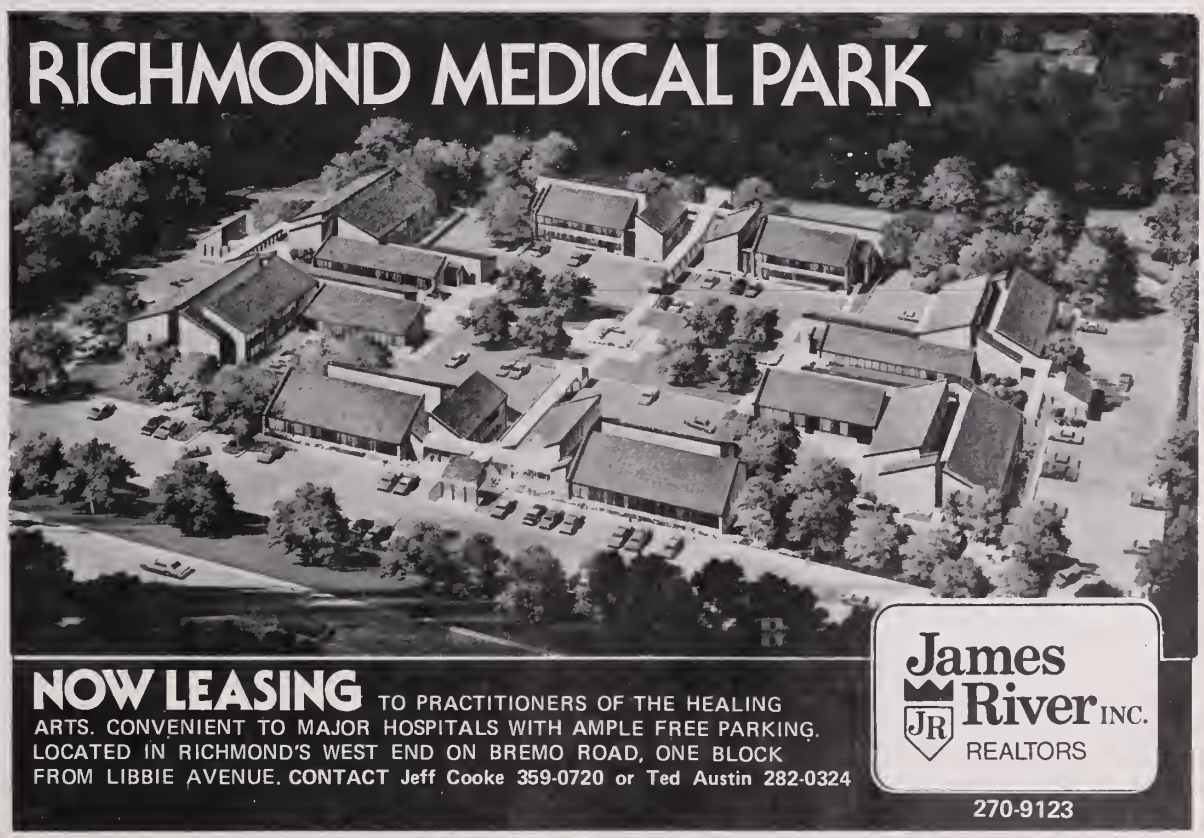
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EMERGENCY ROOM PHYSICIAN: 351-bed community hospital, southwest Virginia and Upper East Tennessee area. Tennessee license required. Salary: minimum guarantee $40,000 plus annually. Fringe benefits. Hours: 42 weekly average. Write or call: Executive Director, Bristol Memorial Hospital, Bristol, Tennessee 37620, phone 615-968-1121.

CHILD PSYCHIATRIST: Immediate opening. $15,000 to $20,000 for approximately half time. To head up medical psychiatric staff in community Child Guidance Clinic. Metropolitan area population 500,000 plus. Opportunity for private practice available. Liberal fringe benefits. Equal Opportunity Employer with Affirmative Action Plan. Write or call Betty Reames, Memorial Guidance Clinic, 2319 East Broad Street, Richmond VA 23223—804/648-1605.

PHYSICIAN'S ASSISTANT—Graduating from the University of Iowa program in June and am interested in relocating in Virginia. Primarily interested in general or family practice but will consider other specialties. Contact: Geoffrey LaGary, 2103 Davis Street, Iowa City, Iowa 52240, (319) 337-5604.



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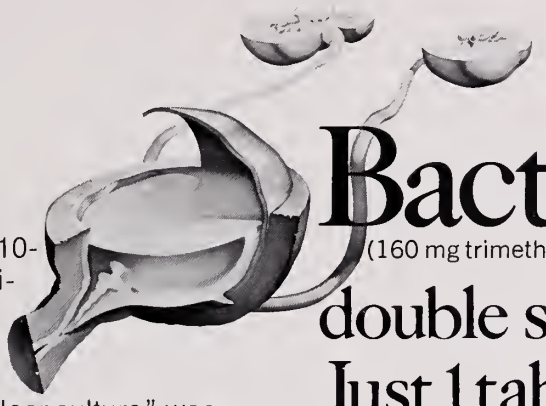
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10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions were mild (*e.g.*, nausea, rash), more serious reactions can occur with these drugs. See manufacturers' product information for complete listing.

Note: Bactrim single strength tablets were used in these clinical trials. However, studies have established the bioequivalency of Bactrim DS with the single strength tablets.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

double strength tablets Just 1 tablet B.I.D.

Bactrim™

(80 mg trimethoprim and 400 mg sulfamethoxazole)

2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy; maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

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15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

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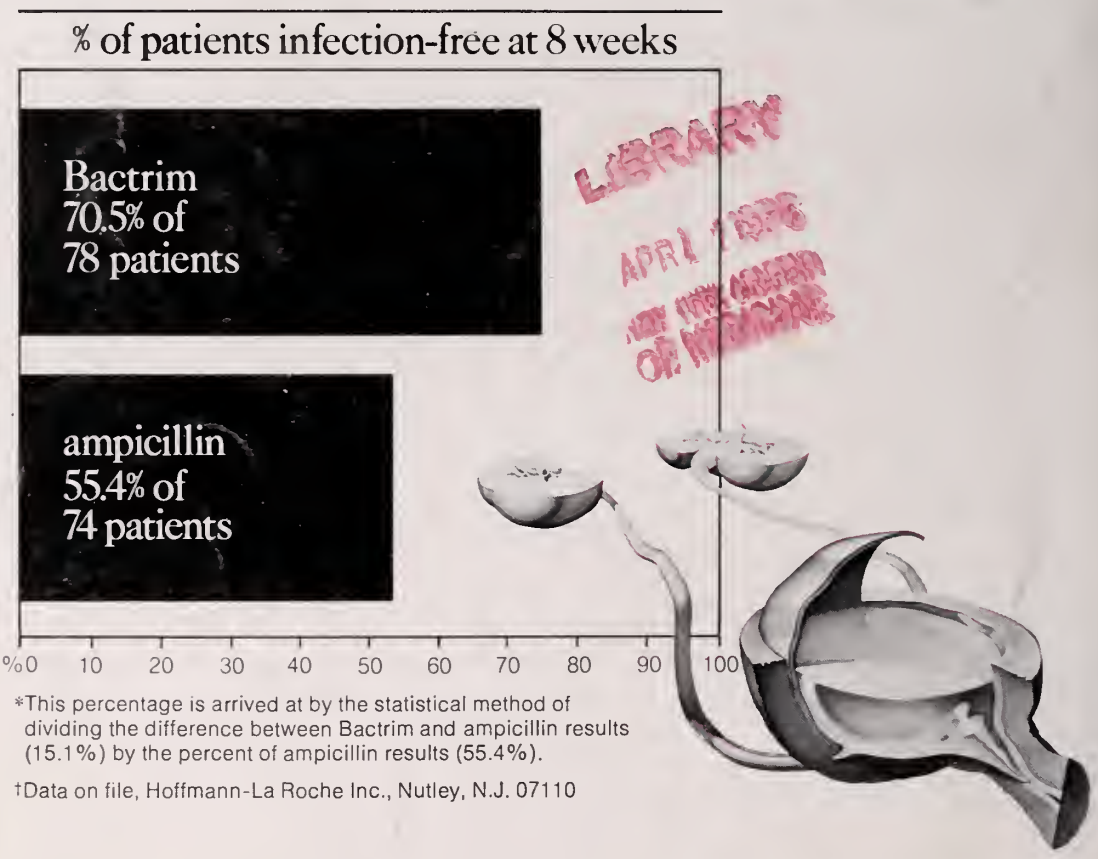
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VIRGINIA MEDICAL MONTHLY

OFFICIAL PUBLICATION OF THE MEDICAL SOCIETY OF VIRGINIA

Vol. 103
MAY
1976

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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in freque y and/or severity of grand mal seizures r y require increased dosage of standard a i- convulsant medication; abrupt withdra l may be associated with temporary in- crease in frequency and/or severity of seizures. Advise against simultaneous i gestion of alcohol and other CNS depre sants. Withdrawal symptoms (similar t those with barbiturates and alcohol) ha occurred following abrupt discontinua e (convulsions, tremor, abdominal and m s- cle cramps, vomiting and sweating). Ke addiction-prone individuals under care

respond to one

According to her major
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tl ugh primarily one of ex-
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a ed by depressive symptom-
o gy. Valium (diazepam)
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d, the depressive symp-
r associated with it are also
t relieved.

There are other advan-
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anxiety with secondary
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a um is pronounced and
q l. This means that im-
ement is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

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anxiety states
with associated
depressive symptoms

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ng age, weigh potential benefit
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fully pharmacology of agents em-
ed; drugs such as phenothiazines,
otics, barbiturates, MAO inhibitors
other antidepressants may potentiate
ction. Usual precautions indicated in
nts severely depressed, or with latent
ession, or with suicidal tendencies.
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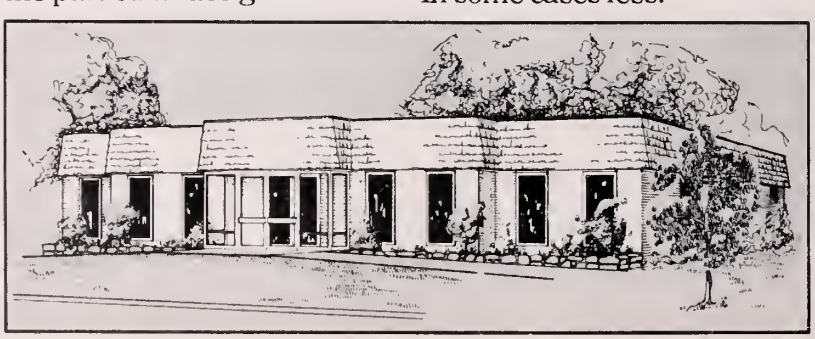
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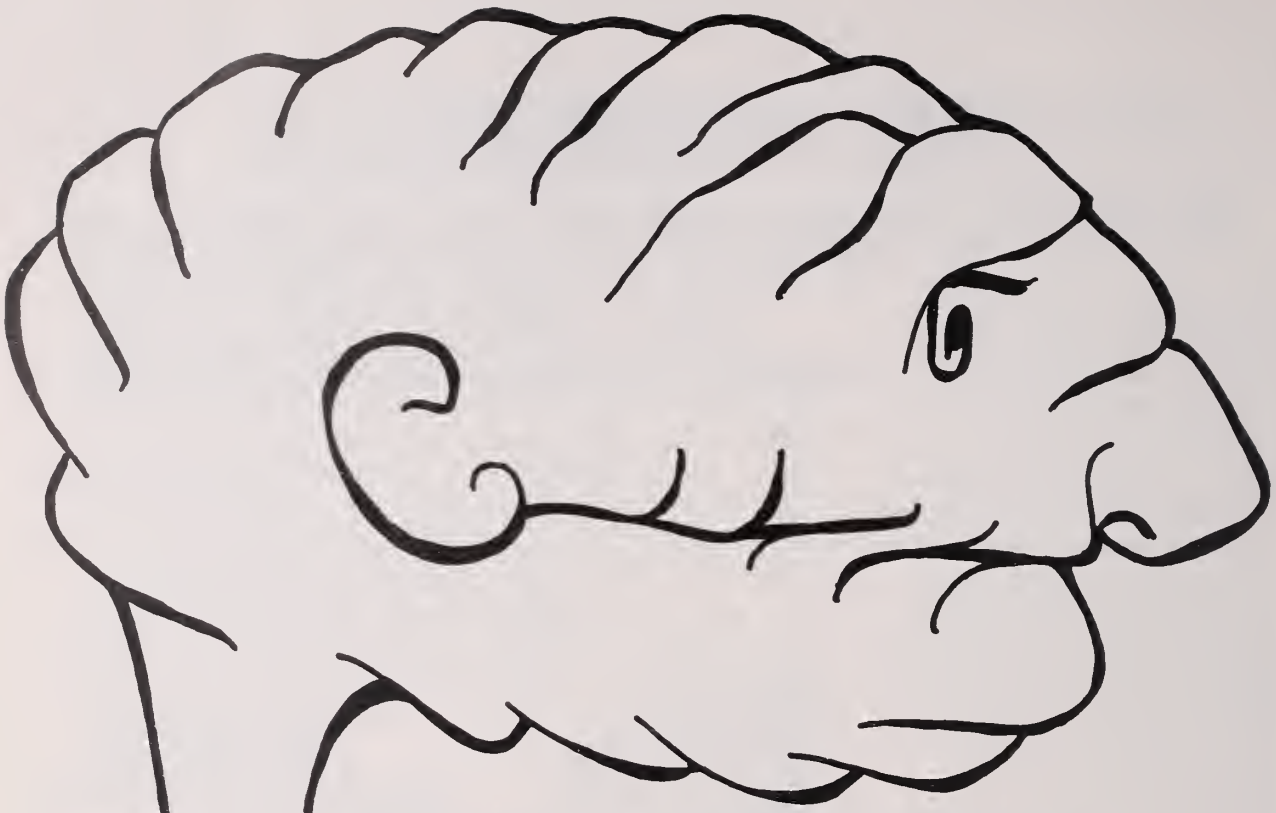
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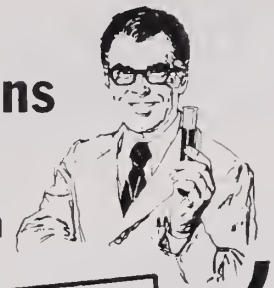
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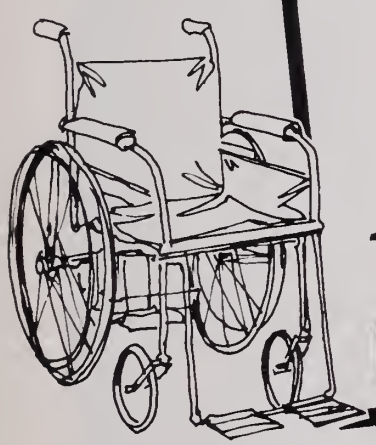
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Point of View . . . .

The Scientific Method Is the Key

A RECENT series of articles in The Times-Dispatch told clearly the risks of negligent or excess medical practice. In that, its readers were well advised. They were not so well advised in two other areas. Some criteria given for identifying a good physician were invalid, and expectation that the quality of medical practice can be perfected through education, audits, and penalties is hopeless. The following observations may correct these false impressions.

A few unfit physicians can and do practice medicine. Some do so even in Virginia, although the quality of our practice appears far better than in most states. Much credit belongs to Virginia's medical schools, whose graduates have set high standards for practice. Our physicians must now work harder than ever to remedy or remove poor practitioners, but our quality must also be controlled by patients. It is to patients that quality or lack of it is first exposed. The general public must learn what makes good practice, must seek and pay only for good practice, and must not reward errors of unfit physicians.

What makes a good practice is not its style, size or price, nor its diplomas, medical school affiliations or certificates of continuing education. The real measure of a good practice is the degree to which a physician employs the classic scientific method in search of every patient's safety, economy and comfort.

"The scientific method is constantly in every good doctor's mind. . . ."

Science has recently earned a bad reputation by confusion with technology. Science and technology must not be equated. Technology may be useful, useless or harmful. In pursuit of health, however, the scientific method can do no harm and is the only guarantee of maximum safety. People should learn to recognize the scientific method in medical practice.

The method consists of (1) observing all significant facts (including emotional and social data), (2) lucid statement of problems, (3) hypothesis, or the making of tentative diagnoses, (4) prediction of natural consequences of each problem, (5) prediction of good and bad consequences of possible treatments, (6) recommendation and trial of whatever prediction appears safest (often no treatment), and (7) continuing observation of outcomes for proof or disproof of hypotheses. An unpredicted outcome is a new observation, requiring a new hypothesis and a new trial.

"Courts and agencies cannot eliminate the small per cent of bad practice."

The scientific method is constantly in every good doctor's mind, in prescribing a vaccination, in withholding the pill, in deciding whether or not to perform a test, when to operate, and even whether to unplug a respirator. Always the physician must study, diagnose, predict and be certain his prediction is fulfilled. These are the crucial steps of good practice. It is not prescriptions but the scientific method which makes for true safety and assurance. Each step of the method should be apparent to a patient or to a patient's responsible relative. If any step is not apparent, the physician should be asked to explain his or her thinking. Where thinking is incomplete and unscientific, the patient is both shortchanged and endangered.

How can negligence and overtreatment be minimized? Some deterrent may be found in penalties imposed by hospitals, licensing boards and courts advised by good physicians. Punishment for repeated errors, however, is not

Reprinted from the Richmond Times-Dispatch *of February 12, 1976.*

enough. Courts and agencies cannot eliminate the very small percent of bad practice anymore than they can prevent Kepone spills. Prevention of negligent medicine is best exercised by a public able to recognize the scientific method in medicine. To each patient belongs the ultimate power and responsibility for making medical practice safe and economical, or unsafe and wasteful. Patients abdicate that responsibility at their own risk.

HUNTER H. MCGUIRE, JR., M.D.

Box 51, MCV Station
Richmond VA 23298

No One Promised Us a Rose Garden

THE WORDS of a popular song, "I beg your parden, I never promised you a rose garden," might be appropriate regarding our present economic situation and prospects.

A highly paid physician's assistant ($24,000 a year, and he earns it in the coal country) recently told me, "Do you know, if I receive a 10% raise and the cost of living goes up 15%, then I have been docked 5%."

Currently 44 federal judges are suing jointly for back pay based on inflationary losses dating to 1969. They have had only a $12,000 pay raise, which has not, they say, kept up with inflation. (Incidentally, they have one of the finest pension systems in existence, guaranteeing them full salary after 15 years on the bench.) Their case is based on a clause in Article III of the U. S. Constitution which states that federal judges shall suffer no pay decreases while in office. From 1920 to 1939 federal judges paid no income tax, based on a decision citing this same Article. This was reversed in 1939, and Justice Felix Frankfurter wrote then that "they have trivialized a great clause."

". . . we should do everything possible to hold down our fees. . . ."

The judges and the physician's assistant have this much in common with most of us: we have come to expect a constantly increasing standard of living. Hence the title of this article.

The "American Dream" has for some years been under attack, in particular from the Third and Fourth worlds as well as the Communist block. We are all familiar with the statement that the United States, with only a fraction of the world's population, uses nearly half of the world's energy. The standard rebuttal, of course, is that we produce so that we can afford this, plus we have the ability to export our surpluses.

A basic law of economics is that unless one produces more than any increase in monies that he receives, it is, on the face of it, inflationary. Even more inflationary is the practice of larding on excess increases to justify any and all increases for goods or services.

It is particularly disturbing that just as the current depression, the worst in 40 years, appears to be receding, giving the economy time to catch up, a fresh round of wage demands leading inevitably to further inflation appears to be just over the horizon, possibly soon after the presidential election. Physicians using fee for service, still in the majority, are apt to feel the cost push pressure on their fees and, due to the physician shortage, are less subject to the restraints of the market place.

The medical profession, much as it is being criticized, is still the most respected in this country. For this reason and for our own self-interest, we should do everything possible to hold down our fees, as well as hospital costs, so much of which are under our direct control.

Martin Donelson, Jr., M.D.

1035 Main Street
Danville VA 24541

For a Senator, a Physician Spells Out Some Positions

In tumultuous sessions, the 1976 Virginia General Assembly passed two bills dealing with medical malpractice. The approved measures set a $750,000 limit on malpractice awards, establish a malpractice review panel to decide a claim's validity, and create a joint malpractice underwriting association for doctors and hospitals.

Soon after the bills passed, Dr. John A. Martin, Roanoke, a past president of The Medical Society of Virginia, received a letter from State Senator Dudley J. Emick, Jr., Fincastle. A few days later the same letter was received by Dr. Martin's wife, whereupon Dr. Martin was provoked to answer Mr. Emick as follows.

Dear Mr. Emick:

The Bill passed by the General Assembly is in general a good start; and although not as much as the medical profession wanted, it should help, and with experience be modified for the better.

You state that the goal of this legislation should be to insure complete compensation to the injured person. As close to this subject as I have been over the past decade, I have yet to learn of an instance where compensation was lacking when a court decided the person had a true case. This is not the problem, nor is it the reason the malpractice situation exists.

You say further that your primary interest in this legislation is to protect the public and "to call attention to the responsibilities of the medical profession for policing its own profession."

I'm not certain whose attention you are trying to get with this statement. It certainly is an implication that the medical profession is not meeting its responsibilities, a position that appeals to many politicians because it is easy to sell to the uninformed public, which is eager to blame any medical problem on the doctors. I take strong exception to this statement. Policing a profession intimates that wrong doers are prevented from doing wrong. If all the wrongs of the so-called wrong doers were eliminated, there would be an infinitesimal impact on the malpractice problem. If you will examine the record, you will find that the large recoveries are not against physicians who are chronic wrong doers. In most cases, high recoveries come from the high risk branches of medical practice, such as neurosurgery, orthopedic surgery, anesthesiology, and others. And more often than not,

". . . the large recoveries are not against physicians who are chronic wrong doers."

the leaders, the respected senior people in these professions, are the ones sued, not because they did wrong, but because a poor, a bad, or an unexpected result took place.

How does one police this situation? Policing anything implies police powers, and the medical profession does not have this. Even so much as publicly implying that another physician is practicing improperly subjects that person to a possible suit claiming defamation of character. As far as policing is concerned, this is the responsibility of the State Board of Medicine, which has the authority, is protected, and has shown much success protecting the public from the few wrong doers they can prosecute.

Very truly yours,

John A. Martin, M.D.

2037 Crystal Spring Avenue, S.W.
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Diagnostic Ultrasound

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A quick, safe, and accurate technique for reconstructing the anatomy of internal abdominal organs and differentiating cystic masses from solid tumors is diagnostic B-mode ultrasound. Some of the possible uses in diagnosis are discussed and several examples given.

DIAGNOSTIC ultrasound utilizes pulsed sound of very high frequencies in the approximate range of two million cycles per second or 2 megaHertz (MHz). Sound waves at this high frequency behave similar to light, in that they can be focused and reflected. Sound is both sent from and received by a small crystal or transducer. The sound is sent out from the transducer in a narrow beam and is reflected at interfaces between media of different acoustical properties (acoustical impedance).

Acoustical impedance depends mainly on the density of the tissue. The greater the difference in the acoustical impedance of two media, the more sound is reflected at their interface. For example, with a gas-solid interface, where there is a great difference in density, essentially all sound is reflected. This is why the normal lungs cannot be evaluated and why adequate scans usually cannot be obtained in patients with gastrointestinal gaseous distension. With a liquid-solid or solid-solid interface there is less difference in acoustical impedance so that while some sound is reflected, enough sound is transmitted to allow visualization of deeper structures.[1,2]

The reflected sound can be displayed on an oscilloscope screen or a television monitor in one of three forms: A-mode, where the intensity of the reflected sound at various points along a single pathway is displayed as amplitude peaks off a baseline; B-mode, where a 2-dimensional image is formed by dots representing reflected sound from various points within the body; and M-mode, which is a motion display used primarily in echocardiography to evaluate the motion of the heart valves. The image obtained on the oscilloscope and television monitor screen can then be recorded on polaroid film, a paper printout, 70 mm film, xray film or videotape.

In B-mode scanning multiple images are obtained usually in longitudinal (sagittal) and transverse planes with oblique scans obtained as needed. Each scan represents a laminographic section so that multiple scans are needed to evaluate a given area. During the examination the controls are manipulated so that strong (high gain) and relatively weaker (low gain) sound beams are utilized. This is essential in the differentiation of solid from cystic structures. At low gain setting cystic, as well as homogeneous solid structures, may appear sonolucent or anechoic (no echoes are obtained from within the structure). However, at high gain settings internal echoes will begin to appear in solid structures while cystic structures remain sonolucent (anechoic). The diameter of the smallest abdominal mass visualized by ultrasound is approximately 2 to 3 cm. However, the minimum size of a detectable lesion also depends on its consistency and relationship to adjacent structures. It is easier to discriminate a cyst from the surrounding tissue than a solid tumor from the surrounding tissue. Therefore, a small lesion which is fluid-filled may be visualized, while the same

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sized lesion which is solid will be overlooked.

While ultrasound as used in physical therapy, with its continuous, very high output, has destructive properties, there is no evidence at the present time that pulsed diagnostic ultrasound has any harmful genetic or somatic effects.[3]

Renal Ultrasonography

B-mode scanning of the kidneys has been one of the most rewarding ultrasonographic procedures. Because the kidneys are posterior, the patient is almost always examined in the prone position. Ultrasonograms are obtained in both longitudinal and transverse planes. At normal gain settings, the kidneys appear as relatively sonolucent gray "kidney bean" shaped masses with some localized central echoes from the collecting system.

The prime use of renal ultrasonography is to evaluate masses seen on excretory urograms. The renal ultrasonogram should be performed after the urogram and with the roentgenogram present for evaluation during the ultrasonographic procedure. The accuracy of ultrasound to differentiate a solid mass (potentially malignant) from cystic lesions (likely benign) is approximately 95%.[4,5] It is now felt that following the demonstration of a renal mass on an excretory urogram, a renal ultrasonogram should be the next diagnostic procedure, unless the lesion is clearly malignant on the urogram.

A renal cyst provides an optimal situation for ultrasound since there is a fluid-solid interface at the cyst wall. A cyst appears as a sonolucent area even at high gain settings. In addition, there is good propagation of the sound beam through the fluid so that the far wall of the cyst is well delineated (Fig. 1). In contrast, a solid renal mass does not have a good acoustical interface with the normal renal parenchyma. The solid renal tumor will fill in with echoes at higher gain settings. There also is poor propagation of the sound beam so that a well delineated far or distal wall is not demonstrated (Fig. 2). At the lower limits of resolution, a solid tumor can be obscured by the normal renal parenchyma. Therefore, when a normal ultrasonogram is obtained in the face of an abnormal urogram, the examiner should suspect a solid renal tumor and further evaluation with angiography should be considered.

If a cyst is demonstrated on the ultrasonogram and further diagnostic confirmation is desired, a percutaneous cyst aspiration under ultrasonic guidance can be performed. Ultrasound can delineate the extent of the cyst and show how far below the skin surface the cyst



Fig. 1. Prone, longitudinal (sagittal) ultrasonogram of the left kidney (K) with cranial to the left and caudal to the right. An 11 cm. in diameter sonolucent mass is seen at the upper pole of the left kidney. The distal wall is well defined (arrows), and no internal echoes are present, indicating good through sound transmission by a fluid filled cyst (C).

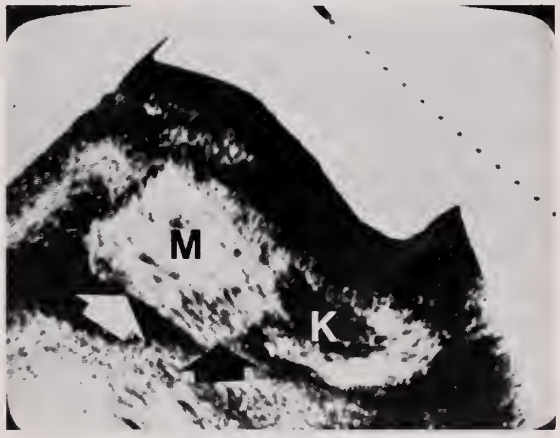


Fig. 2. Prone, longitudinal (sagittal) ultrasonogram of the right kidney (K) with cranial to the left and caudal to the right. A 7 cm. in diameter solid mass (M) arising from the superior pole of the right kidney. Many echoes are seen in the center of the mass and the far wall is indistinct (arrows) due to poor through sound transmission by this hypernephroma.

is located. By the use of a special ultrasonic transducer with a central hole for passage of a needle, the cyst size can be continually monitored during aspiration without using fluoroscopy, thereby eliminating radiation hazard to the patient and examiner.[6]

Because renal ultrasonography does not depend on renal function for visualization, the technique can be extremely useful in localizing nonfunctioning or poorly functioning kidneys for the purpose of percutaneous renal biopsy. Bolton et al have found ultrasonography to be superior to excretory urography, radionuclide scanning and fluoroscopy for this purpose.[7]

Abdominal Aortic Ultrasonography

Ultrasound has proved to be extremely accurate in diagnosing abdominal aortic aneurysms.[4,8] The fact that aortic ultrasonography is safe and noninvasive makes it an excellent screening procedure for evaluating the presence of aneurysms, especially in older patients. The abdominal aorta is readily accessible to examination with the patient in the supine position. Because it is filled with blood, the aortic lumen appears as an echo-free structure, making it easy to determine aortic diameter and course. Aneurysms appear as a localized increase in aortic diameter. Not only can an aneurysm be detected, but the presence of thrombus in the lumen can be ascertained, and differentiation can be made between the wall of the aorta, the thrombus, and the remaining aortic lumen.

Pancreatic Ultrasonography

Pancreatic ultrasonography is useful in the detection, diagnosis, and delineation of pathologic processes in the pancreas.[4,9] It is most accurate in the diagnosis of pancreatic pseudocysts, where it can rapidly differentiate a mature pseudocyst ready for surgical intervention from an edematous pancreas. Ultrasound can also be used in the long term followup of pancreatic pseudocysts, evaluating for change in size and possible recurrance following surgery.

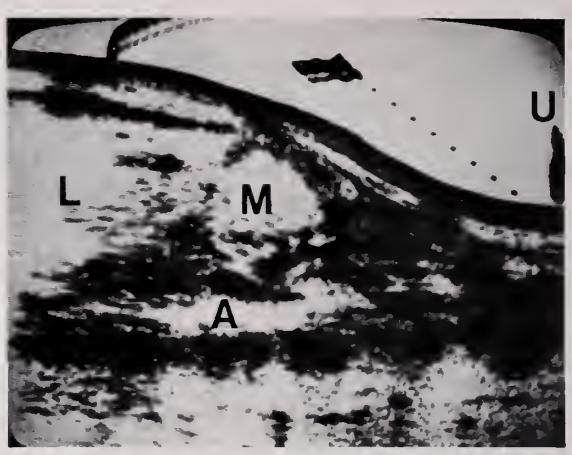


Fig. 3. Midline supine longitudinal (sagittal) upper abdominal ultrasonogram with cranial to the left and caudal to the right. There is a 5 cm. in diameter mass (M) anterior to the aorta (A). The mass has multiple internal echoes and somewhat ill-defined borders indicating a pancreatic carcinoma. U = umbilicus, L = liver.

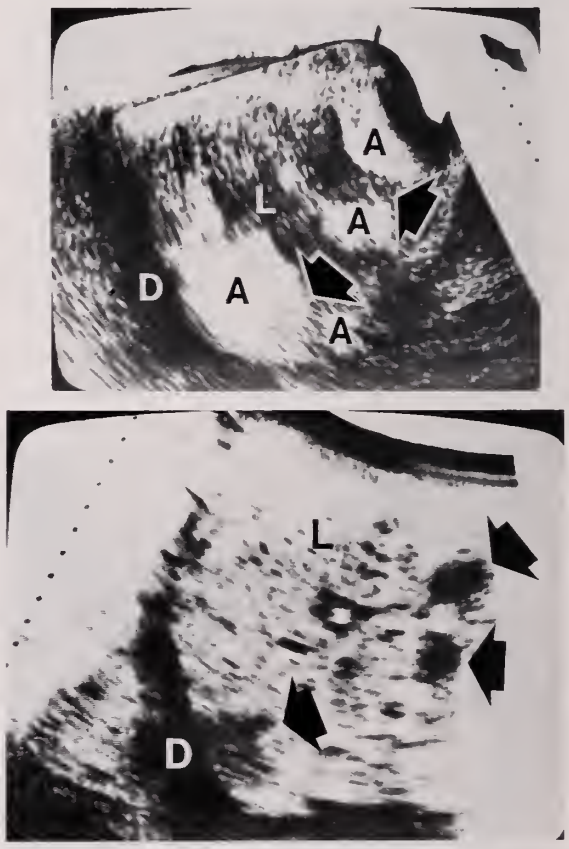


Fig. 4. Supine, longitudinal (sagittal) hepatic ultrasonograms through the right lobe of the liver with cranial to the left and caudal to the right. Figure 4A (above) shows multiple sonolucent areas (arrows) in a patient with multiple hepatic abscesses (A).)Figure 4B (below) shows many echo producing areas (arrows) emanating from solid lesions within the liver, metastases from colon carcinoma. D = right hemidiaphragm, L = normal liver parenchyma.

While the accuracy in the differential diagnosis of pseudocyst from pancreatitis or carcinoma is high, confidence and accuracy is frequently low in the differential diagnosis of chronic pancreatitis from pancreatic carcinoma (Fig. 3). This is because they both may present as solid pancreatic masses with identical sonic characteristics. When a localized solid pancreatic mass is identified on the ultrasonogram, the technique of ultrasonically guided percutaneous pancreatic biopsy may be employed to make the differential diagnosis between pancreatic carcinoma and chronic pancreatitis.[10,11] This technique uses a special biopsy transducer which allows a B-mode pancreatic ultrasonogram to be produced; then a 23-gauge needle is directed through the transducer into the visualized pancreatic mass. Cytological samples of the pancreatic mass are then obtained.

Liver and Gallbladder Ultrasonography

The normal blood vessels, bile ducts and fibrous stroma of the liver provide many good echo reflecting surfaces. Therefore, the normal liver appears as a fine, speckled pattern of echoes on the ultrasonogram. This normal pattern is interrupted in disease states. Both primary and secondary liver tumors may be identified as areas of either decreased sound density (relative sonolucency) or a marked increase in number of echoes (relative sonodensity). Ultrasonography may be used to evaluate response to therapy of known liver lesions. It frequently is used in conjunction with radionuclide liver scans. These two imaging techniques should be considered complimentary to each other. It is impossible to determine if focal defects noted on a radionuclide liver scan reflect hepatic abscess or solid tumor. This differential can be easily made on the ultrasonograms[11] (Fig. 4).

Histologic diagnoses of hepatic lesions may be made utilizing ultrasound directed biopsy techniques. The lesion is localized ultrasonically and its position marked on the patient's skin. The depth of the lesion from the skin is determined, and the special biopsy transducers used to direct the biopsy needle accurately into the lesion. This technique may be used for both solid tumors and suspected abscesses.

Gallbladder ultrasonography (cholecystosonography) is performed with the patient supine and in a fasting state. The gallbladder is usually easily seen in normal patients as a smooth walled sonolucent mass. Gallstones, as small as 5-7 mm in diameter can be identified with a high degree of accuracy and confidence. Gallstones display three different ultrasonographic patterns: internal echoes, contour irregularities of increased sonic density, and sonic shadows (Fig. 5). Sonic shadows are caused by the virtual total reflection of sound at the bile-gallstone interface. This creates an echo-free (anechoic) area distal to the stone. The diagnosis of cholelithiasis may be made when the gallbladder itself is not identified and only the sonic shadow is seen.



Fig. 5. Supine, longitudinal (sagittal) ultrasonogram demonstrates two prominent gallstones (arrows) within the gallbladder. A prominent sonic shadow (SS) distal to the gallbladder is noted. L = Liver, K = right kidney.

Gallbladder diameter, as measured on the ultrasonogram, is of little diagnostic help. This is because the normal gallbladder has a great size range. In general, a gallbladder diameter of 4 cm or above in a patient with jaundice, is usually taken to mean extrahepatic biliary obstruction. If dilated intrahepatic biliary ducts are identified, the diagnosis of extrahepatic biliary obstruction can be made with confidence. Confidently identifying dilated

intrahepatic biliary ducts may be difficult. They usually appear as clusters of ovoid, branching, or reticular sonolucencies, especially in the region of liver hilum.

Gynecologic Ultrasonography

In pelvic scanning it is essential to have a full urinary bladder. This serves two purposes. The bladder raises the pelvic organs out from the deep pelvis and behind the pubic symphysis so that they can be easily seen, and it provides a ready reference point. While normal uterus and cervix can usually be seen, the normal fallopian tubes and ovaries cannot be identified.

Ultrasound can identify and confirm the presence of a normally positioned intrauterine device. This reduces the need for radiography and hysterosalpingography.[12]

Pelvic ultrasonography is accurate in the diagnosis of size, position and structure of pelvic masses 2 to 3 cm or larger in diameter. Cystic masses are sonolucent, with sharp margins and good through transmission of sound, while solid masses have irregular borders and multiple internal echoes. The exact histologic diagnosis cannot be made ultrasonically as a simple ovarian cyst, endometrioma, hydrosalpinx, or cystic ovarian carcinoma may all appear similar ultrasonographically. It is, therefore, important to evaluate the ultrasonograms with a complete knowledge of the patient's history and physical findings.

Usually, uterine fibroids present little diagnostic problem. They appear as an irregular enlargement of the uterus or an irregular mass extending from the uterus. At higher gain settings, there are invariably some internal echoes, especially when compared with the urine filled bladder.[13]

Obstetric Ultrasonography

Ultrasound may be used in the diagnosis and assessment of early pregnancy. After approximately six postmenstrual weeks the gestational sac can be visualized as a ring within the uterus. The integrity of the gestational sac or ring together with a high site of implantation are good prognostic signs. Serial ultrasonograms demonstrating growth of the ring and enlargement of the uterus over subsequent weeks indicate normal development. The gestational sac usually starts disintegrating by 9 or 10 weeks and is incorporated into the enlarging uterine cavity so that by 12 to 13 weeks it is no longer seen. The placenta can usually be identified by approximately 9 or 10 weeks, and the fetal head by approximately 14 to 15 weeks.[14] A measurement of the fetal biparietal diameter obtained at approximately 20 postmenstrual weeks gives an accurate measurement of fetal age within plus or minus 7 days. Before 16 and after 30 weeks and in diabetic patients, the accuracy of this method decreases.[15]

Ultrasonography is extremely accurate and is the method of choice for placental localization. This is important when amniocentesis is contemplated, as well as in the diagnosis of placenta previa.[16,17] Serial ultrasonographic examinations have demonstrated placental migration toward the fundus during pregnancy, probably due to differential enlargement of the uterus. This phenomenon frequently converts a partial or marginal placenta previa into a simple low implantation.

Variations of normal pregnancies can also be diagnosed by ultrasound, including multiple gestation, fetal anomalies, such as anencephaly and hydrocephaly, hydramnios and hydatidiform mole.[18]

The ultrasonographic diagnosis of ectopic pregnancy is difficult, but occasionally can be made. The positive diagnosis can be made only in the presence of an empty uterus and a definite gestational sac identified outside the uterus.[13] This is rarely seen. However, even if the extrauterine gestational sac cannot be identified, valuable information can frequently be obtained by identifying an empty uterus in the face of a positive pregnancy test.

Summary

The use of diagnostic ultrasound has been steadily growing to the point where it is now an integral part in the evaluation of most patients with abdominal complaints. Only a few of its common uses have been presented.

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Psychologic Reactions to Myocardial Infarction

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The person with initial manifestations of myocardial infarction is likely to deny their import and may die through failure to get help. Similarly, the survivor may use denial to cope with depression and anxiety in the coronary care unit. The author reviews these problems, the grave responsibilities they create for the physician, and ways to cope with them.

MYOCARDIAL infarction strikes down more than a million people in this country each year, and of the 675,000 for whom this is a fatal event, 176,000 are under 65 years of age. The availability of coronary care units has lowered mortality rates from 70% to 30%, and the provision of sound prehospital care by mobile coronary units has significantly lowered the number of deaths occurring en route to the hospital. One community reports a 75% reduction after this specialized emergency service was put in operation.[1]

Since many persons with coronary artery disease drop dead soon after the symptoms of myocardial infarction manifest themselves, the prompt recognition of the signs of acute myocardial infarction, and an appropriate response to them, are crucial to survival. Delay in responding is responsible for many deaths, and the main reason for delay is a psychological one—indecisiveness on the part of the sufferer[2]. It is not unlikely that many who drop dead have experienced warning symptoms but have denied them and have accordingly failed to seek medical help in time.

It is difficult to persuade people that action should be taken immediately when symptoms are experienced, and it is no less difficult to help the survivor of a heart attack cope appropriately with his situation during the phase of acute illness and the subsequent period of convalescence and rehabilitation.

Denial as a Coping Tactic

How do people cope with the knowledge that they have an illness likely to be fatal, or to cause irreversible impairment? How does the previously well person react to the grim implications of sudden overwhelming pain, such as that of a myocardial infarction? Many deal with terrifying information about their bodies by the simple expedient of refusing to acknowledge it and shutting it out of their thoughts. Some are so successful in this maneuver that, although they remain in touch with reality in other matters, they can state with an air of authority and confidence that they do not have the condition attributed to them. Since the clinical implications of denial demand consideration, both in arriving at a diagnosis and in assessing treatment outcomes, it is not surprising that it has interested physicians for many years; as early as 1885 Von Monakow[3] discussed denial, in accounting for the refusal of blind patients to acknowledge that they could not see.

Anna Freud[4] was the first to identify denial as a common defense mechanism in childhood. Its manifestation in a relatively early phase of development led to its being considered a primitive form of defense, its survival into adult life indicating an "advanced state of psychic disease". Much of the psychiatric writing on denial connects it with psychosis[5]. Physicians who care for psychologically sound per-

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sons faced with physical catastrophe are, however, accustomed to seeing such nonpsychotic individuals use denial as a means of maintaining emotional equilibrium under extreme stress.

The definition of denial as "the conscious or unconscious repudiation of part or all of the total available meaning of an illness in order to allay fear or anxiety, and to minimize emotional stress" [6] falls short of describing all that is involved. Denial may better be seen as a process that may or may not employ such mental strategies as rationalization, minimization, isolation, projection, or dissociation. For the purposes of this paper, denial is considered a conglomerate of the 31 variables listed on the Hackett-Cassem Denial Scale[7,8], i.e., delay in reporting symptoms of myocardial infarction; dependence on others for seeking help; minimization of present symptoms; statements about being healthy enough to go home; displacement of symptoms to organs other than the heart; complaints about symptoms unrelated to the cardiovascular system; unwillingness to acknowledge fear of death, of another attack, of becoming an invalid, of the sound of the monitoring alarm, of the heart's stopping or becoming irregular; failure to show alarm when symptoms peak; verbal denial of fear connected with past or present dangers; revelation of a lifestyle of flirting with danger, risk-taking; nonchalance, coolness, imperturbability exhibited in the hospital; the use of cliches in describing attitudes toward life stress; mockery toward worry; the use of nicknames implying immunity, superior strength and toughness; projection of anxiety to others ("My wife was afraid, but it didn't bother me!"); and the avoidance of direct questions.

Before the common use of denial in myocardial infarction was recognized it was customary to refer to "silent" or "painless" infarctions as antecedents of the main event. One astute observer has suggested that patients supposed to have experienced these "silent" attacks may have experienced characteristic identifying pain, failing to acknowledge its serious import and minimizing what was in fact appreciable physical distress. Hackett and his group[9–13] undertook the first systematic investigations of denial related to acute coronary disease, and classified its use on three levels. In *major denial* the patient with myocardial infarction unequivocally states during his hospital stay that he is without fear and that he has not experienced fear in the past. When the patient initially denies being afraid but eventually admits to some fear, we speak of *partial denial.* The patient who either complains of his anxiety or readily admits being afraid uses *minimal denial.*

Response Before Hospitalization

As postulated, delay seems to be a function of denial. Several factors underlie delay in the response to signs of acute myocardial infarction[14]. The first impulse of anyone who experiences chest pain, whatever his educational level may be, is to say, "It's just indigestion", rather than, "It's my heart!" He usually then takes an antacid and waits for the pain to subside. The half time for reaching medical help is about four hours. Symptom severity and delay correlate negatively; the more severe the symptoms are, the more obvious it becomes that help must be sought. Those in pain who recognize that their symptoms originate from the heart seek help sooner than those who displace the cause to some other organ. Most sufferers are influenced by a member of the family to seek help, but friends or even strangers may be more successful than a spouse in getting the sufferer to call a doctor. When the influence of others on delay is correlated with denial, we find that the individual who uses minimal denial needs little urging by others to call a physician when he has coronary symptoms, but the one using major denial will not move until he is goaded into action. The partial denier classifies midway between these two extremes[14].

The Hospital Phase

What happens to persons with acute myocardial infarction who do get to the hospital? Cassem and Hackett[15] have described the natu-

ral history of emotional reactions to myocardial infarction in the coronary care unit. Of 441 patients consecutively admitted to one coronary care unit, 135 (32.7%) were referred for psychiatric consultation during their period of treatment. The most frequent reasons for referral were anxiety, depression, and behavior that demanded special management. Requests for consultation were distributed differently in time for each of these difficulties. Most requests because of anxiety were made early—on the first or second day of the patient's stay on the unit. The peak for consultations for depression came on the third and fourth days. The distribution for management problems appeared to be bimodal, with a higher peak of referrals on the second day and a lower one on the fourth.

The natural history of the emotional reactions of the average victim of myocardial infarction who is admitted to a coronary care unit can be inferred from this study. It is usual for the patient to be *anxious* when admitted to the unit a few hours after his experience with overwhelming chest pain. Finding it incredible that he really has had a heart attack, he begins to *deny* that this was the case as he begins feeling better physically; he may even insist on returning to work in the absence of any officially communicated confirmation of heart damage. The full implications of his experience come into focus by the third or fourth day, however, and trigger *depression.* The more severe the effects of the infarct, the deeper the depression is likely to be. Before long, the patient whose premorbid personality characteristics prejudice his acceptance of the situation will start behaving in ways that puzzle or irritate his caretakers. This is likely to occur somewhere around the fourth day, by the time the immediate threat to life seems less dire, and is particularly common in dependent or passive individuals[15].

How do patients respond to being hospitalized in a coronary care unit? A study directed by Hackett[12] shows that CCU patients are undercomplainers; most are either reassured by the monitor or indifferent to its presence. Many are anxious and depressed. Fewer than half of them are disoriented in time, and such confusion is mild, transient, and easily correctable. Delirium is uncommon. Survivors of cardiac arrest recall little of the circumstances that attended it, and typically are not terrified by witnessing the cardiac arrest of others. Most patients are pleased to be able to leave the unit and see their transfer as an encouraging development.

The three levels of denial previously noted are evident in the CCU. An inverse relation between denial and mortality was found in Hackett's study[12]. Not one major denier died during the study interval, and two of those who did die were minimal deniers. The type of denial behavior the patient uses will influence his management, and perhaps his prognosis as well; for this reason it should be identified. Patients who deny only in part want reassurance but do not know how to ask for it directly; they may be much more apprehensive than they appear, and might benefit from tranquilizing medications. Reassurance, encouragement, and adequate amounts of tranquilizing medications would be the treatment of choice for the minimal denier also. It is more difficult to prescribe treatment for the major denier. The fact that no major denier died during the study cited may indicate that strong adherence to denial has value, at least for immediate survival.

Appropriate management of the emotional reactions of the patient in the coronary care unit can in many cases contribute to his swift and uncomplicated recovery. The patient told about the typical emotional experiences of recovery from heart attack will find them less overwhelming than the patient who has no idea what to expect. The physician's primary aim must include the minimizing of emotional stress. Cognitive aspects of coping with stress should be emphasized; the different aspects of heart disease should be explained, and pertinent drawings can convey to the patient what is going on. This approach makes it easier to dispel the misconceptions most patients have about impotence, invalidism, loss of work capacity, and the like. The meaning of such symptoms as weakness should be routinely

clarified also. A group of clinicians[15] who used tranquilizing medications for their heart patients found them so useful that they suggest they should be used routinely. The patient's natural defense mechanisms should be brought into play; for example, the man who can project his fear and say that his wife was more worried about his symptoms than he was, can be encouraged to let the machines and the staff "worry" about the threatening aspects of the situation while he concentrates on the more optimistic signs[15].

What happens when the patient is transferred out of the coronary care unit? The most hazardous point in hospitalization for heart attack is the patient's removal from the CCU to the general hospital, or from the hospital to the home[2]. Infarcts, arrhythmias, and extensions of infarcts seem likely to appear on removal from the CCU to the convalescence room, or at the time of discharge from the hospital. Excretion of urinary catecholamines is much greater than usual at such times; anxiety ratings are also elevated. The patient is glad to leave the unit, seeing his transfer as an indication of improvement, but at the same time he is a bit leery about surrendering the protection of the unit. The move thus becomes a mixed blessing. It can be made somewhat easier[2] for the patient by telling him to anticipate feeling a bit shaky when he goes and reassuring him that this is quite usual. He should never be moved suddenly and without preparation, to suit the convenience of the caretakers or demands on the unit. The availability of an intermediate unit—something between the CCU and a convalescent ward in terms of nursing care—is most helpful.

But the single most important factor in helping the patient during this period of transition is open communication between him and his physician. The latter should anticipate his patient's psychologic reactions and deal with them candidly. Misconceptions should be dispelled, and appropriate reassurance for the many apprehensions patients have while convalescing in the hospital after being in the coronary care unit should be offered[2].

Convalescence at Home

Although the patient may have made an excellent adjustment to his experience during his days in the hospital and be delighted to return home, new and unexpected anxieties may await him in his familiar surroundings. He had not previously thought of risk in connection with going up and down stairs, driving a car, or lifting a child in his arms, but now he must "be careful" and think twice before performing any of these simple acts. He can no longer eat, smoke, or drink to please himself, and he wonders not only whether sexual activity is now too strenuous to be safe but whether he is still competent sexually. Having had one attack, he is likely to think of the possibility of another at any time and in any place, and he knows more than he did about the incredible swiftness with which death can come. Coping mechanisms such as repression or denial, which he may have used successfully to thread his way through life, may fail him.

Group psychotherapy for patients who have this experience in common has been tried with excellent results.[16,17] Grouping permitted the relative gravity of the different concerns these people shared to be assessed. It also provided a record of how their anxiety was reduced as they expressed and shared their feelings. An understanding of what bothered these survivors most helped their physicians to give them the specific advice they so badly needed, and each participant gained strength and relief from association with others who could understand and from the opportunity to express worries they found it necessary to hide in other company. In fact, the group interacted so readily that the nurse who conducted one group (with access to the physician for specific advice) had no difficulty with any reduction of attendance or participation although the sessions met over a considerable period of time.

It is not enough to tell a patient to relax and get enough rest; those who find it impossible to relax should be given hypnotics or tranquilizers and be urged to take them. The limits of exertion the patient can safely make should be clearly indicated and "enough rest" should

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be defined in terms of a day's routine. Limitations should be given practical application and shared with the patient's spouse[2]. Although it used to be customary to forbid sexual intercourse for the first three weeks—or three months—after a heart attack, this limitation was not based on any absolute knowledge and depended on what physician was giving the advice. Patients were sometimes told that they could engage in intercourse until they felt chest pain; this is hardly an encouraging bit of advice, or one calculated to promote competence! No doubt a great deal of silent suffering about this aspect of recovery was undergone before it became possible to publish data on sexual activity and myocardial infarction[18], cardiologists seeing such advice as being beyond their purview. Hellerstein[18] holds that anyone who can walk around the block without experiencing angina or arrhythmia need not modify his usual habits of intercourse; that is a reasonable rule, but the techniques of intercourse might have consideration. Physical demands are perhaps less when the woman is positioned on top, for example, although the increase in pulse and blood pressure that occurs during sexual activity arises from autonomic response in orgasm and physical excitement[2]. Any necessary limitations the patient must observe should be described as temporary when this is true, and some substitutes can be offered for limitations that are permanent.

Resumption of Activities

Many who have had a heart attack never return to work. How much is this withdrawal due to cardiac disability, and how much to psychologic problems? Nagle and his group[19] assessed the relative importance of these factors, in a study of 115 patients examined about four months after a heart attack. Only 49% of these returned to work, but in 52% of those not working clinical signs of heart dysfunction were altogether absent. Only 50% of patients with angina were at work. Of those with minor cardiac deficiency 66% were working, but only 27% of those with major cardiac deficiency were working. The investigators reported that anxiety and depression were the most common noncardiac causes of persistent invalidism. Among those who had returned to work, anxiety was evident in only 11%. An adverse psychologic reaction was as common among those who had made an excellent cardiac recovery as among those who had severe heart disease. An important cause of invalidism was inadequate medical instruction about the fitness to work, when to return to work, and how to prepare for the resumption of normal activities.

Stern[20] has identified somewhat more precisely those psychologic factors that influence the quality of the long-term psychosocial adjustment of the survivor of an acute myocardial infarction. He tentatively identified two groups of patients who classified at opposite ends of the rehabilitation spectrum. Those who used denial as their major coping tactic (25% of the sample) had "good psychosocial outcomes"; exhibiting the behavior described by Hackett et al[7,8], they did not experience depression or anxiety after leaving the hospital, and resumed work and their normal sexual activity within a short time, much more rapidly than patients classifying in other personality groupings. However, depressed patients (13% of the sample) had "poor psychosocial outcome," reporting to the physician in their first posthospital visit significant anxiety and depression and staying depressed for a year thereafter. These patients were much slower than the first group in returning to work and in resuming sexual activity. Inasmuch as the depressed patient can be identified early in his treatment, an effort should be made to offer him appropriate help to ameliorate his problems.

The suggestions about preparing the patient to be discharged from the hospital apply as well to the transitional experience of returning to work after a posthospital stay at home. The importance of keeping interpersonal communication between the patient and his physician open and candid at all times cannot be overemphasized.

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Future Implications for Hospital-Physician Contracts

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The growing significance of contractual arrangements between hospitals and physician specialists is reviewed. The question of increased federal control and physician accountability is discussed, kinds of contracts compared, and recommendations offered.

IT IS not likely that medical care services will see an abatement of the recent escalation of federal controls in the foreseeable future. To the contrary, there are still a number of vulnerable areas, toward which the next round of controls might be focused. One such potentially vulnerable area is that of contractual arrangements between hospitals and hospital-based physician specialist. This vulnerability stems from increases in the number of such arrangements and their impact on the costs of medical care.

A primary reason for speculating that contractual arrangements of hospital-based physicians are a potentially vulnerable area for further federal controls is the marked growth in the number of such arrangements. During the past two decades, there has been a noticeable shift in the delivery of primary care from the physician's office to the hospital. This shift has resulted in larger numbers of physician specialists who practice full-time in the hospital, usually under some form of contractual arrangement. As additional subspecialization occurs in medicine, nursing, and the allied health professions, medical practice will tend to concentrate in larger medical centers, where advanced medical equipment and highly trained specialized medical manpower are available.

There are two important implications of this trend toward greater numbers of hospital-based specialists. First, as the number and variety of specialists increases and corresponding increases in cost to the hospital become evident, there will be increased federal pressure to regulate the financial provisions of these contractual arrangements. The professed objective will be to insure that the contract is in the best interest of the public and that the physician or hospital does not profit unduly. Second, as the number of specialists increases, they will assume greater responsibility for supervision and management of the hospital's manpower and budget. In doing so they will find that the plethora of legal and regulatory controls promulgated by the federal government will have an even greater impact on them, largely through controls imposed on the institution. For example, the federal government has already instituted general control programs such as utilization review and PSRO's. The net result may mean that the hospital-based physician will find himself held strictly accountable, through controls over his contractual arrangement, for such management responsibilities as cost containment and improvements in manpower productivity.

Increased Pressure to Regulate Contracts

A cogent argument can be offered that pressures to regulate physician specialists contracts will increase. As the number of physicians practicing in hopitals increases, the form of

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contractual arrangements will become more important to both parties and the public. One reason is that the type of contractual relationship established between the hospital and physician specialist can have a significant bearing on hospital costs. The degree of impact on costs depends upon the type of contractual arrangement and specific provisions in the agreement. Some forms of contractual arrangements are also potentially inflationary, as will be illustrated.[1]

Further evidence can be presented that there will be increased pressure to regulate hospital-based contracts. For example, as a result of an increase in the number of physicians practicing in the hospital, hospital-based physicians now control departments that account for approximately 20-25% of the institutions' budgets, and they have either a direct or indirect influence over a large percentage of hospital costs.[2] As the federal government probes deeper into hospital affairs in its search for ways to contain costs, we may expect attention to focus on departments with hospital-based specialists and on their contractual arrangements.

Increased Physician Accountability For Management

A second major implication of the increase in hospital-based specialists is the likelihood that these physicians will find themselves held more strictly accountable for certain managerial responsibilities that heretofore many have been able to avoid. Although there is a discernable trend in increased physician involvement in administration and in service on governing boards, many hospital-based specialists have traditionally left to the chief technician such managerial responsibilities as the attempt to control costs, improve productivity, and use resources optimally. Many existing contracts between hospitals and these specialists do not pinpoint the accountability for these management concerns. Future contracts are likely to address managerial accountability for productivity more specifically.

During the past several years the federal government has placed increased national emphasis on controlling inflation through finding ways to improve employee productivity.[3] Hospitals are highly labor-intensive organizations and have traditionally rated low on the indices of employee output measuring productivity. To address the unique problems of health services, the government initiated a Hospital and Health Care Productivity Study in 1973. Objectives of this study were to identify barriers to productivity, recommend means of removing such barriers, and identify ways to increase productivity.[4]

Comparison of Contracts

There has been and continues to be public interest in improving productivity in hospitals. Of greatest importance to the physician specialist is the fact that the Social Security Administration is presently examining the effect of different types of contractual arrangements on department efficiency.[5] Such research has traditionally been a forerunner to mandating additional controls in health services.

Should such controls come, hospital-based specialists will want to insure that their contracts clearly delineate the limits of accountability. Perhaps for the first time, they will find themselves interpreting managerial reports and becoming involved with management engineers, systems analysts, and a host of other specialists related to finding ways to improve productivity.

There are a number of important considerations in selecting a particular form of contract. The financial arrangement, provisions for insuring quality of care, and the degree of independence in professional practice are but a few of the considerations important to the physician specialist.

There exists a wide variety of contractual arrangements by which the professional services of physician specialists are obtained by the hospital; however, only the principal types of contracts in use today will be considered in this analysis. Table I lists the most common types of contractual arrangements between hospitals and physician specialists.[6]

The question of relative advantages and disadvantages of particular forms of contract is

TABLE I

ANALYSIS OF PRINCIPAL TYPES OF CONTRACTUAL ARRANGEMENTS
BETWEEN HOSPITALS AND HOSPITAL BASED PHYSICIANS

TYPES OF ARRANGEMENTS	ADVANTAGES	DISADVANTAGES
1. Percentage of gross departmental charges. Hospital pays the physician a percentage of gross billings minus customary courtesies and discounts. The percentage may also be adjusted for bad debts, free services, specific allowances and health services to employees. There may be minimum and maximum provisions.	1. Usually yields greatest possible income if utilization is high. 2. Contract remuneration provisions are relatively simple. 3. Departmental and/or hospital inefficiencies do not affect income. 4. Provides incentive to expand quantity and level of services.	1. Little incentive to actively manage the department. 2. Unless special provisions are made, income fluctuates directly with utilization. 3. No incentive to increase productivity or control costs because no provision is made for sharing savings.
2. Percentage of net department charges. Hospital pays the physician a percentage of the department's income that remains after deductions for direct expenses (salaries, supplies etc.), depreciation of equipment, and, in some cases, indirect expenses such as administration.	1. Permits and encourages physician to discharge his public responsibility for controlling health care costs. 2. Tends to promote a closer working relationship with the hospital.	1. Must usually assume responsibility for cost containment, resource management, and employee productivity. 2. In some institutions professional status with colleagues may be affected by the arrangement. 3. Involves relatively greater commitment of time to administrative duties.
3. Salary. Hospital pays the physician at regular intervals a negotiated amount which usually includes employee benefits.	1. Provides guaranteed level of income, fringe benefits, and other salary advantages. 2. Tends to provide more opportunity to pursue research and educational interests. 3. Tends to promote better relations between the physician and administration.	1. May require physician to be relatively more involved in administration. 2. Little or no incentive to expand services. 3. Income level may be too low to attract high caliber colleagues. 4. Hospital has control over regulation of the percentage attached to professional components.
4. Fee for service. The physician is paid based upon a fee schedule which divides the total bill to the patient into a portion for the hospital and the specialist. The physician either bills the patient directly for his services or the hospital collects all charges and pays the fees collected to the specialist.	1. Promotes closer relationship between patient and physician. 2. Physician has independence in setting fees for service. 3. Yields a measure of professional identification apart from the institution. 4. Provides for clear identity and recognition of the worth of the professional component. 5. Increases physician's prerogatives in determining procedures performed.	1. May increase administrative costs for physician and hospital. 2. May create patient confusion and ill will because of dual billing. 3. Tends to drive overall charges upward. 4. Physician must usually assume greater responsibility for operations. 5. May create additional problems in collections and bad debts.
5. Lease. The physician leases either the space or space and equipment from the hospital. He bills the patients individually for his services and pays the hospital for various facilities furnished. Control of the department's personnel varies according to the	1. Provides the greatest measure of professional and financial independence. 2. Provides greater freedom in selection of equipment.	1. May present difficulty in obtaining necessary support and coordination with other departments. 2. May foster undesirable split in employee loyalty. 3. Physician must accept total management responsibility.

dependent upon the perspective being considered. The physician specialist should understand not only his perspective, but that of the hospital and the public. For example, the physician may seek a contract that protects his professional prerogatives, maximizes his personal income, optimizes his working conditions, and minimizes his commitment to administrative and supervisory duties. In contrast, the public may consider its interests best

served by a contract that provides only reasonable compensation for both hospital and physician, while at the same time including provisions for productivity incentives and cost control. The ideal type of contractual arrangement would satisfy all interests. Since few things are ever ideal, the relative advantages and disadvantages should be identified and considered in contract negotiations. Some of the more important pros and cons are listed in Table I. From the public point of view, a percentage-of-net-department-charges arrangement would be most satisfactory, if the contract further provides for a definitive statement on responsibility for department management. The principal advantage of this arrangement from the public viewpoint are the inherent interests by the physician in containing costs and in striving for maximum employee productivity consistent with quality of care requirements. The assumption is that if these factors directly affect the physician's income he will be more inclined to better manage his department.

The least acceptable arrangements from the public perspective are probably the percentage-of-gross and direct-billing forms of contract. The percentage-of-gross arrangement offers no incentive to the physician to strive for effectiveness and efficiency.

The decision regarding which arrangement is best for a particular physician in a particular situation must be an individual one. A percentage-of-gross-charges arrangement may yield the greatest income and involve the least commitment to management of the department. In contrast, a lease or fee-for-service arrangement may yield greater professional independence but involve far more personal commitment to management of personal affairs. The significant point is that, in addition to being aware of these personal considerations in selecting the form of contractual arrangement, hospital-based physicians must now carefully weigh the potential impact of their contracts on the public. Widespread failure to consider the impact on the public will likely result in some form of control to insure that the public interest is adequately protected.

Recommendations

In preparing for future contract negotiations there are a number of important questions the hospital-based specialists should consider.

- What effect will the form of the contract have on hospital patient care costs?
- Does the contract contain provisions that permit the specialist to exercise judgement and authority in controlling costs and increasing productive output while sharing the benefits of this effort?
- Does the contract specifically provide for the necessary personnel, equipment, and related support needed to continually improve patient care?
- Do contract provisions clearly specify the specialist's role, responsibility, and accountability in departmental management?
- Does the contract provide for a professional practice that is flexible, yet has adequate quality assurance provisions?

These questions illustrate the type of public scrutiny that may occur if studies now being conducted show that federal controls are needed to improve productivity and control costs in departments headed by hospital-based specialists. Specialists must give serious consideration to both the form and provisions of their contracts in order to insure that their agreement with the hospital is in the best interest of the public. The public interest will be served by a contract that provides for high quality care at a reasonable cost. At the same time, the contract should provide fair compensation for the specialists and allow them freedom and flexibility to pursue professional interests.

(*References on page 390.*)

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Case Reports . . . .

Aplastic Anemia Due to Methimazole

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Antithyroid compounds have frequently been associated with the production of agranulocytosis, but reports of aplastic anemia induced by these agents are rare.[1,2] Here is a case report describing the abrupt onset of aplastic anemia in a patient following treatment with methimazole, indicating a side effect of the antithyroid drugs not commonly appreciated.

Case Report

A 38-year-old housewife was admitted to the Riverside Hospital on 30 April 1974 for surgery to correct uterine prolapse. Preliminary examination revealed moderately active rheumatoid arthritis, of which she had complained for the past 22 years. A diffuse goiter, accompanied by weight loss, heat intolerance and sinus tachycardia, was found. The T_4 was greater than 20 ug/100 ml, 24-hour radio-iodine uptake 71%, and cholesterol 110% mg. On 7 May 1974 the planned surgery was cancelled, therapy with methimazole 10 mg every 8 hours was initiated, and the patient was discharged for outpatient followup. On 22 May the methimazole dosage was increased to 20 mg every 8 hours and maintained until 14 June. Weekly office leukocyte counts were normal through 31 May. During this same interval she took acetylsalicylic acid 600 mg every 6 hours for the arthritis, propoxyphene hydrochloride 64 mgm as indicated for pain, and meprobamate 400 mgm as needed for sleep.

On 15 June the patient developed a generalized petechial rash and heavy menstrual bleeding with the passage of large clots; by 16 June she developed nausea, vomiting, and fever. On admission to the intensive care unit her examination revealed a blood pressure of 140/70 mm Hg, pulse 140/min, respirations 24, and an oral temperature of 105 degrees. Many petechiae were observed. A diffusely enlarged thyroid gland, a Grade II/VI ejection systolic murmur over the entire precordium, and marked lower abdominal tenderness with vaginal bleeding were identified. The leukocyte count was 1,700/mm^3 with 30% neutrophils, 68% lymphocytes, and 2% monocytes. The hematocrit was 32%, platelet count 32,000/mm,^{3} and reticulocytes 0.1%. The patient was treated with reverse isolation, a cooling blanket, nasogastric suction, intravenous fluids, sodium cephalothin 2 gm IV every 4 hours, gentamicin 80 mgm IV every 8 hours, and clindamycin 500 mg IV every 6 hours. Hydrocortisone sodium succinate 100 mg IV every 8 hours was given until 19 June, then 50 mg IV every 8 hours until 26 June, when it was stopped. Examination on 18 June showed a leukocyte count of 600/mm^3 with 100% lymphocytes, a hematocrit of 24%, platelet count 12,000/mm,^{3} and reticulocytes 0.1%. A posterior iliac crest bone marrow aspiration and biopsy revealed marked hypocellularity with 6% erythroid cells, 2% myeloblasts, 86% lymphocytes, 1% plasma cells, and 5% histiocytes (Figure 1). Despite moderate vaginal bleeding through 23 June, neither packed red cells nor platelet transfusions had to be given. On 28 June she was afebrile. All antibiotics were stopped and laboratory data revealed a leukocyte count of 3,000/mm^3 with 31% neutrophils, 68% lymphocytes, and 1% monocytes. The hematocrit was 26%, platelet count 100,000/mm^3 and reticulocytes 0.8%. The hyperthyroidism was treated with 7.5 mc of radioactive iodine, and acetylsalicylic acid 600 mgm every 6 hours was resumed. She was discharged from the hospital on 2 July 1974 to be followed in the office.

During the week of 7 October 1974 she used meprobamate 400 mg on three consecutive evenings for sleep. On 14 October the leukocyte count was 7,300/mm^3, with 66% neutrophils and 34% lymphocytes. The hematocrit was 36%, platelet count 360,000/mm^3, and reticulocytes 1.6%.

Discussion

This patient developed aplastic anemia after taking 1.8 grams of methimazole over a 38-day period. Although meprobamate has been presumed to be a cause of aplastic anemia,[3] it cannot be incriminated as a cause of her disease, since exposure after full recovery produced no recognizable harmful effects.

The basic defect in aplastic anemia is unknown. Some of the mechanisms leading to

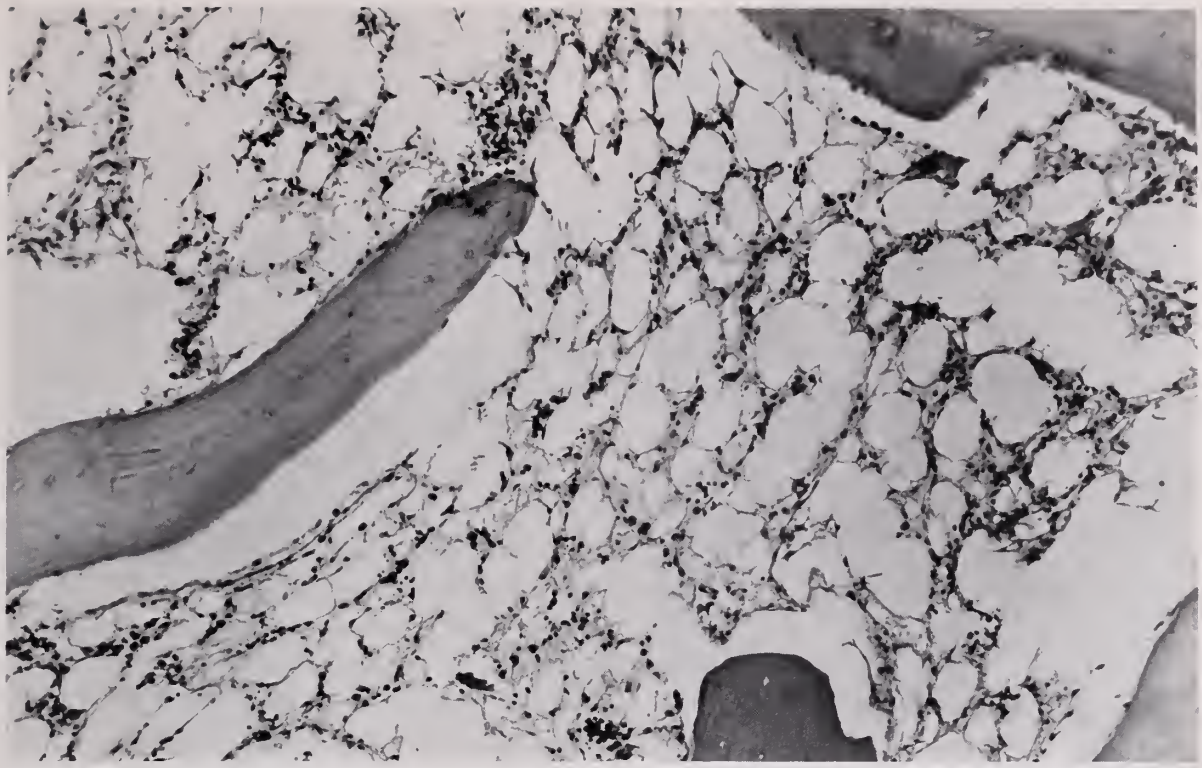


Fig. 1. Posterior iliac crest bone marrow biopsy showing marked hypocellularity (hematoxylin and eosin). Magnification x 100.

pancytopenia include ineffective hematopoiesis with cell death in the marrow, formation of defective cells that are rapidly removed from the circulation, sequestration and/or destruction of cells as a result of antibodies, and, finally, trapping of normal cells in a hypertrophied, overactive reticuloendothelial system.[4]

McIntyre[5] has demonstrated inhibition of particle stimulated release of 14 CO_2 from normal leukocytes by acute phase serum from a patient with propylthiouracil induced agranulocytosis. Pisciotta,[6] too, examined the serum of a patient who developed agranulocytosis during treatment with methimazole and found no leukagglutinins but a suppression by acute phase serum on 14 CO_2 release by normal leukocytes similar to that of McIntyre's patient. These studies clearly show that antibodies to human leukocytes are present in some types of drug-induced agranulocytosis. Unfortunately, studies of this nature could not be performed on this patient. The rather rapid onset, quick and complete recovery, contrasted to other forms of drug-induced aplastic anemia, suggests an immune mechanism rather than some permanent stem cell injury.

In this case it is again demonstrated that an antithyroid drug can induce aplastic anemia. The mechanism of injury to the bone marrow required to produce pancytopenia remains to be identified.

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Facial Sporotrichosis in a Child

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Recent reports indicate that cutaneous sporotrichosis is not uncommon in children.[1-3] The initial diagnosis is most often staphylococcal pyoderma, but the lesion fails to respond to therapy with antibiotics. In one series, there was a delay ranging from three weeks to 2½ months in establishing the correct diagnosis.[1] We report a patient with typical sporotrichosis to increase the awareness of this disorder in children.

Case Report

A 6-year-old boy developed a papule on his forehead in January, 1974. The lesion enlarged, ulcerated, and developed a superficial crust within two weeks. The diagnosis of impetigo was made, and he was treated with oral penicillin as well as a topical antibiotic. Despite the therapy with antibiotics, the lesion slowly enlarged over the next two weeks, and the boy developed similar nodules along the left side of his nose and under his left eye. These lesions were asymptomatic and did not ulcerate. He denied any specific antecedent trauma to his forehead but he was an active boy who lived on a farm in northern Virginia. The child was referred to the University of Virginia in February, 1974. On his forehead, he had a raised erythematous plaque, 2 x 3 cm in diameter, with superficial crusting. A violaceous streak extended inferiorally from the plaque to a nontender nodule on the left side of his nose. There were two larger erythematous nodules inferior to the left eye (Fig. 1). Several anterior cervical lymph nodes were palpable bilaterally, but the preauricular lymph nodes were not enlarged. He was afebrile and the remainder of the physical examination was normal.

His hematocrit was 38%, the white blood count was 7,700 with a normal differential, and the erythrocyte sedimentation rate was 11. An intermediate PPD was negative, and the roentgenogram of the chest was normal. A biopsy specimen from the lesion on the forehead showed chronic inflammation with granulomas in the dermis and mild epidermal ulceration. No bacteria, fungi, or acid-fast bacilli were demonstrated with special stains. Cultures for bacteria and acid-fast bacilli were negative, but fungal cultures from the biopsy material grew Sporotrichum schenkii in four days.

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Fig. 1. Primary lesion on forehead with lymphangitic spread to left side of face.

He was started on oral saturated solution of potassium iodide (SSKI), 10 drops t.i.d. The dose was increased in increments of one drop t.i.d. until he reached a maximum of 25 drops t.i.d. There was significant improvement within two weeks and complete healing with mild residual scarring on the forehead in three months. The SSKI was discontinued after four months, and there has been no evidence of recurrence of his cutaneous lesions.

Discussion

Sporotrichosis is caused by Sporotrichum schenkii, a plant saprophyte with a global distribution. Although primary pulmonary and disseminated sporotrichosis occur occasionally, the cutaneous form of the disease is by far the most common, especially in children. The organism probably gains entrance into the skin by traumatic implantation, although less

than half of the children in one report gave a history of injury.[2] The primary lesion usually occurs on an exposed area, most frequently on the upper extremities. The face is a relatively frequent site of involvement in children as opposed to adults. The disorder is seen predominantly in males, presumably as a result of greater exposure.

Sporotrichosis frequently begins as a dusky red, nontender nodule which enlarges over the course of a few weeks to a diameter of 2-4 cm and usually ulcerates. At this stage the diagnosis of superficial pyoderma is usually made, but the lesion does not heal with antibiotic therapy. Subsequently, nodules develop along the draining lymphatics, but the regional lymph nodes frequently are not enlarged. The term sporotrichoid is used to describe this pattern of a primary lesion with secondary lesions along the proximal lymphatics. In addition to sporotrichosis, this pattern can be produced by swimming pool granuloma secondary to Mycobacterium balnei and tularemia. The specific diagnosis is made by culture of the fungus on Sabouraud's agar at room temperature. A moist white colony develops within four to six days, but later the culture turns dark brown or black. Microscopic examination of the culture material reveals septate hyphae that are branched with clusters of small tear-shaped conidia. Unfortunately the organism can rarely be identified in potassium hydroxide preparations of clinical material or on biopsy specimens, even with special stains. Serologic and sporotrichin skin tests are not generally available.

Potassium iodide is effective in the treatment of most cases of localized cutaneous sporotrichosis. Other effective agents include amphotericin B and griseofulvin. The local application of heat may be beneficial as well. Potassium iodide is given as SSKI in juice or milk, beginning with five to 10 drops t.i.d. and increasing this by three drops each day until a maintenance dose of 30 to 40 drops t.i.d. is reached. Improvement is generally noted within one to two weeks, but therapy should be continued for at least one month after the lesions have resolved to prevent recurrences or

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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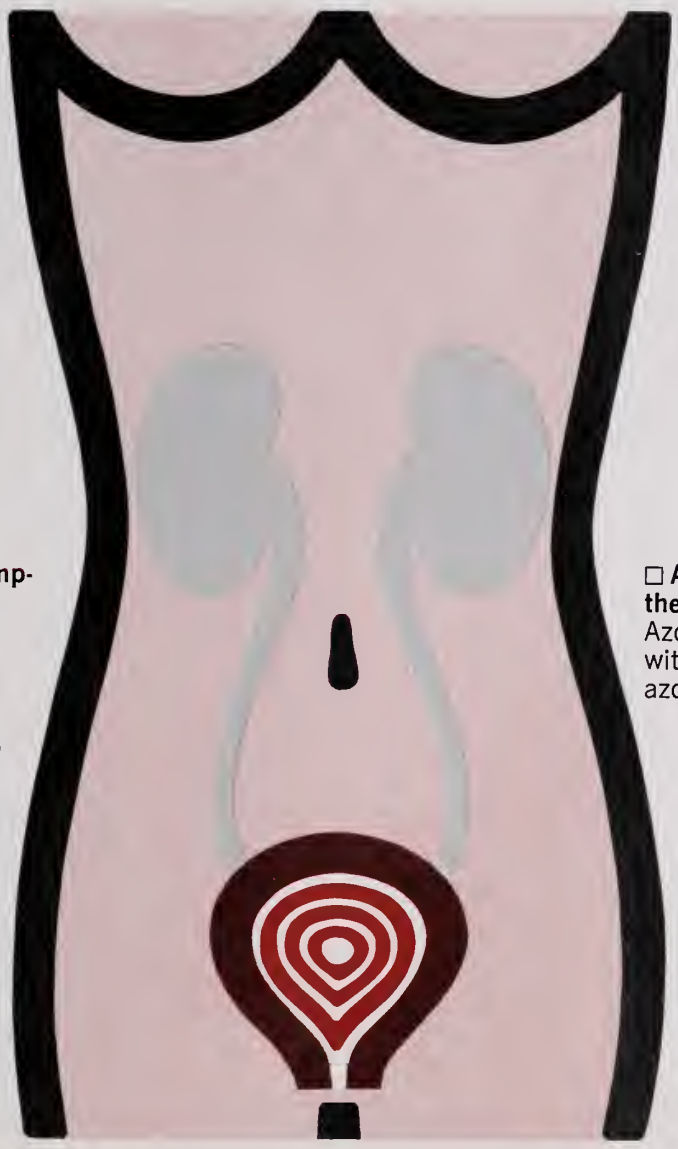
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☐ **Appropriate antibacterial therapy:** up to three days with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole).

*nonobstructed; due to susceptible organisms

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

Warning
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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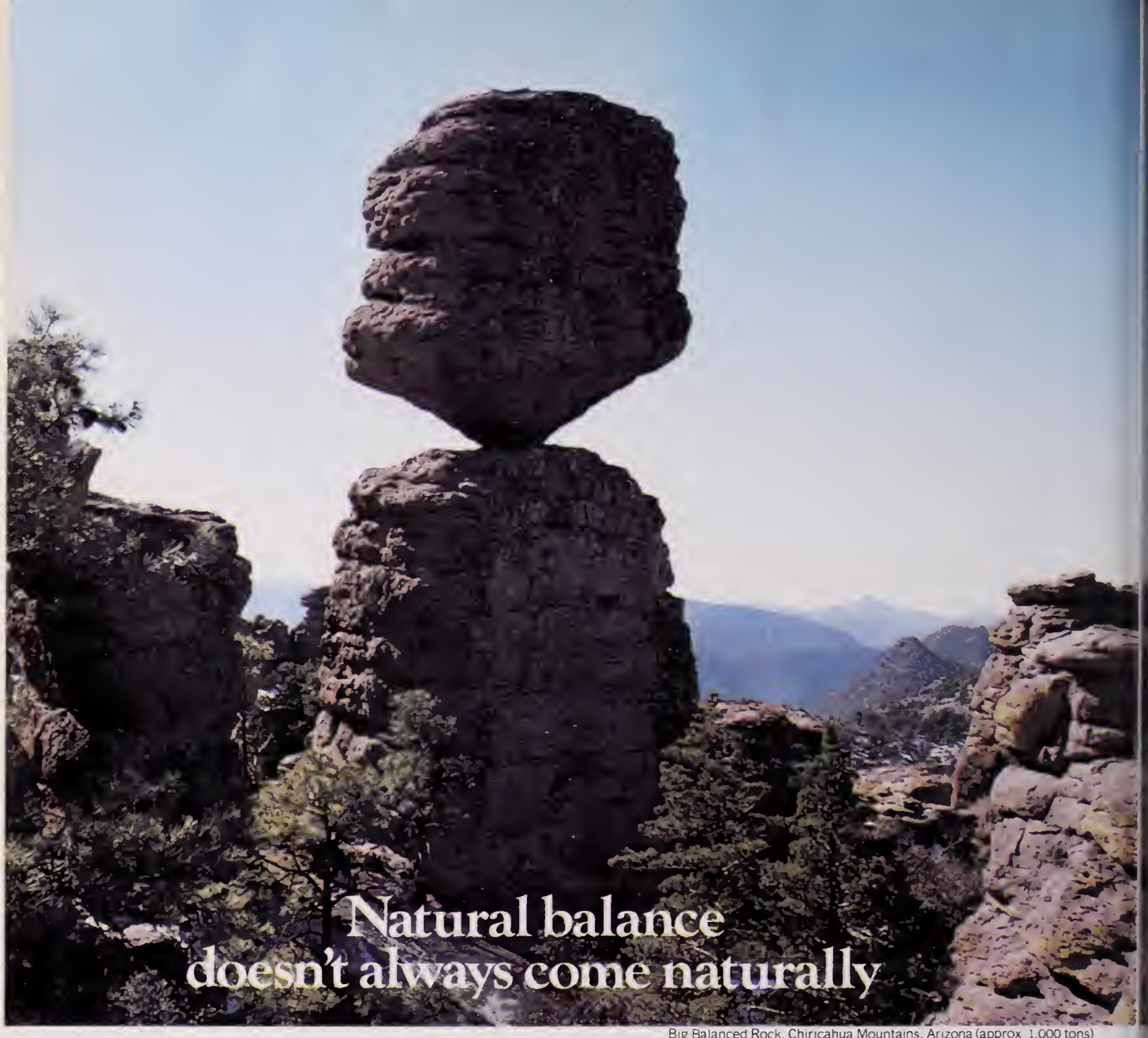
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□ Can relieve nausea and vomiting often associated with vertigo.*
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□ Also available as Antivert (meclizine HCl) 12.5 mg. scored tablets, for dosage convenience and flexibility.
□ Antivert/25 (meclizine HCl) 25 mg. *Chewable* Tablets for nausea, vomiting and dizziness associated with motion sickness.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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relapse, which is rare after a total of three months therapy.[2] Most patients tolerate SSKI quite well, with mild nausea being the most frequent side effect. Other adverse effects include swelling of the salivary glands, excessive lacrimation, cardiac problems and the development of a rash. The side effects generally resolve when the medication is discontinued or the dose decreased. If the patient with localized cutaneous sporotrichosis cannot tolerate SSKI, then oral griseofulvin should be tried before the more toxic amphotericin B is given.

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Acetazolamide and Urinary Stone Formation

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This report describes two patients who developed urinary calculi while receiving acetazolamide, a carbonic anhydrase inhibitor. The metabolic alterations responsible for stone formation secondary to acetazolamide use will be discussed.

Case 1.

A.H., a 57-year-old black man with chronic glaucoma, had been treated with topical pilocarpine and acetazolamide, one gm each day for three years. Surgical treatment of his glaucoma was not considered because of earlier loss of vision in one eye. Twelve hours before admission to Hampton General Hospital, the patient developed severe right flank pain. He denied previous fevers, chills, hematuria, dysuria, or urinary frequency. He had suffered a myocardial infarction five years earlier.

Examination on admission showed BP 160/100, temperature 98°. Other than discomfort on palpation of the right flank, there were no specific abnormalities. Laboratory data included: urinalysis, pH 8.0, many RBC/HPF; CBC, all values normal; urine culture, no growth; serum electrolytes, Na 138 meq/1, K 3.6 meq/1, CO_2 22 meq/1, C1 103 meq/1; BUN 15 mgm%; creatinine 1.4 mgm%; calcium 9.5 mgm%; urice acid 5.0 mgm%. The result of 24-hour urine collection for calcium and citric acid was 432 mgm/24 hours (normal to 300 mgm/24 hours) and 18 mgm/24 hours (normal greater than 150 mgm/24 hours) respectively.

An IVP demonstrated a 2 cm calculus in the right upper ureter and a cluster of small stones in the right kidney (Fig. 1).

A right ureterolithotomy was performed. Stone analysis revealed a calcium phosphate composition. The postoperative management consisted of using hydrochlorthiazide to decrease the patient's hypercalcuria and encouraging an excessive ingestion of fluids. He has not formed new stones in 18 months.

Case 2.

U.B., an 11-year-old black girl, was admitted to Hampton General Hospital because of recurrent pyuria and dysuria. Two years prior to admission the child suffered a cardiac arrest during a tonsillectomy. She was subsequently left with blindness, a mild speech impairment, and muscle



Fig. 1. IVP demonstrating a right ureteral calculus (arrow) in Case 1.

Submitted 8-4-75

weakness in both lower limbs. After a period of intermittent catheterization she was continent of urine, with no more than a 60 cc residual urine. The patient was maintained on diphenylhydantoin, phenobarbitol, primidone, and acetazolamide for seizures. There were no episodes of urinary infection.

Examination revealed a cheerful, well developed black girl. She was blind and required assistance when walking. Specifically, all other neurological parameters were normal.

Laboratory data included: CBC normal; urinalysis, pH 7.5, many WBC/HPF, 10-20 RBC/HPF; urine culture, no growth; serum electrolytes, Na 140 meq/1, K 3.4 meq/1, CO_2 22 meq/1, C1 100 meq/1; creatinine 0.9 mgm%; calcium 9.5 mgm%; uric acid 7.0 mgm%.

An IVP revealed a large bladder calculus.

A cystolithotomy was done. Postoperatively the patient developed a pseudomonas urinary tract infection which was irradicated with appropriate antibacterials. The stone was calcium phosphate (Figs. 2A and B).

The patient has discontinued the use of acetazolamide as an antiepileptic. She has not experienced a seizure in three months. Her urine remains sterile, and the ability to acidify her urine is present.

Discussion

Acetazolamide, a carbonic anhydrase inhibitor, was first used as a diuretic but has since found application in a variety of disorders, including glaucoma and the control of seizures. It has been described in the development of urinary calculi[1-3]. The drug's action creates an iatrogenic form of renal tubular acidosis (RTA), i.e., an alkaline urine in the presence of systemic acidosis. Another metabolic alteration results in a diminished urinary citrate, which is also found in RTA[4] and is described in one of the cases in this report. Ordinarily urinary citrate forms a soluble complex with calcium, thus reducing available ionized calcium, which can precipitate as an insoluble salt.[5] Gordon and Sheps describe a patient taking acetazolamide with hypocitraturia and have reproduced this finding in experimental subjects.[2]

Both patients in this report formed phosphate stones, which is predictable in the presence of urine pH constantly above 7. Elliot's work suggests that an alkaline urine rather than available citrate is the most significant factor in the precipitation of calcium phosphate[6], but in patients using acetazolamide, both metabolic alterations will contribute to calculus formation. Each of the patients described has an additional defect contributing to stone development. The adult has hypercalcuria, while the child has a neurologic disorder associated with a small but relevant residual urine. The use of acetazolamide in patients with urinary abnormalities should be done with meticulous observation or not at all.

(*References on page 390.*)



Figs. 2A and B.
Preliminary and 5-minute film of an excretory urogram of Case 2 demonstrating a bladder stone.

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Indirect Traumatic Optic Atrophy

Khalid J. Awan, M.D.
Norton, Virginia

Optic nerve damage after indirect trauma was known to Hippocrates, who stated, "Dimness of vision occurs in injuries to the eyebrow . . ." [1]. Both unilateral and bilateral blindness on account of indirect traumatic optic atrophy has been discussed in the ophthalmic literature. However, ever-increasing scientific advances and changing rules of the society make it necessary that from time to time the newer aspects of any medical problem be discussed and the older ones either modified or, if true, reemphasized. A few months ago a 50-year-old miner presented himself in the hope of restoring vision in his blind left eye. Several years ago he had been hit in the left cheek with a falling rock and had developed blurred vision in the left eye. He was examined by the company doctor, who attributed this blurriness of vision to the inflammation of the eye and treated it with drops for approximately one month. According to the patient, the doctor did not mention anything about injury to the optic nerve and reassured him at the time of release that the vision would improve gradually. However, the vision went on deteriorating and soon was reduced to hand motion in the superior temporal field. Several months after the accident, the patient consulted an ophthalmologist who, like myself, found a total primary optic atrophy in an otherwise normal eye. We both thought that it could have been the result of that trauma. However, the patient was refused any compensation because, in the original medical report of the company doctor, no reference was made to this possibility. Had that physician made a definite note regarding the state of optic nerve or taken fundus photographs at the time of injury and discharge, the patient's claim could have been settled more justifiably.

The purpose of this paper is to emphasize the importance of ophthalmoscopic evaluation of the eye and photographic records of the fundi in cases of head injuries not apparently involving the eyes, or minor injuries of the eyes in which visual loss is grossly out of proportion to clinical findings. An interesting case of indirect trauma to the optic nerve is discussed.

Submitted 8-27-75.

Case Report

A 34-year-old Negro male was seen with complaint of instantaneous and total loss of vision in the right eye after becoming a victim of hit and run auto accident. No apparent injury was seen in head and face area. He remembered falling on the street and did not lose consciousness at any time afterwards. Physical examination in the emergency room revealed no serious injury anywhere except a few bruises around the knees, and no neurologic deficit was found. He did not complain of headache. He stated that his right eye had gone poor during childhood for unknown reasons, but he could read TV program listings with it before the accident. External eye examination was normal except for absent direct light reaction in OD, although there was brisk consensual reaction. Both pupils were almost equal in size and round in shape. The visual acuity was NLP in OD and 20/20 in OS. Extraocular muscles were normal. Ophthalmoscopic examination showed normal fundus in OS, but OD fundus had a greyish paramacular lesion with an unusual dark halo around the macular area. The optic disc was perfectly normal (Figure 1). X-rays of skull and optic canals were negative. Two months afterwards, the OD developed total optic atrophy with sheathing of arteries and loss of pinkish luster of fundus (Figure 2) and exotropia.

Discussion

Initially the macular lesion in this patient created slight problem in proper evaluation of the case. However, clinical appearance and no change during followup proved it to be an old lesion, and this was also corroborated by patient's story. No immediate change in the retina or the disc proves that the lesion was situated in the cranial or posterior orbital part of the optic nerve. It did not involve the chiasm because no field defects were found in opposite eye. The sheathing of the retinal arteries appeared several weeks after the optic atrophy and was probably due to arteriolar sclerosis in the walls. No changes were seen

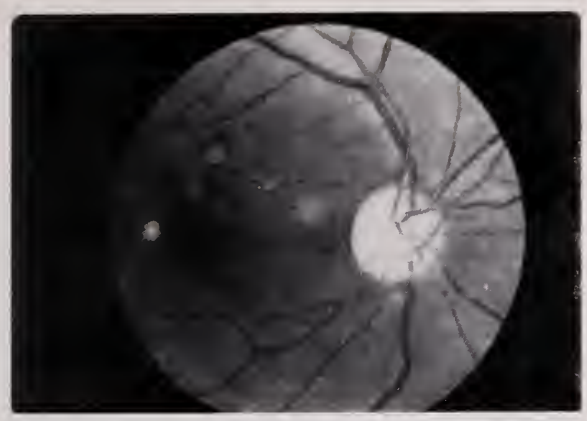


Fig. 1. Fundus immediately after trauma. Optic disc is healthy. Paramacular lesion is old.



Fig. 2. At two months later, total primary optic atrophy. Note the attenuation and sheathing of arteriols.

in the veins. This case could be one of transection of optic nerve due to indirect injury.

The loss of vision in indirect trauma may be temporary or permanent. In the former case, it is a result of concussion of optic nerve resulting from the jolting of the head. Within the optic canal the optic nerve is fixed, and a sudden acceleration or deceleration of brain may cause its bruising or tearing during jolting of the head. The mechanism of optic atrophy in indirect trauma is manifold. According to Seitz,[1] the destruction of nerve fibers at the time of impact on the head is the cause of blindness. Walsh[2] believes that primary contusion necrosis and secondary necrosis from damage to nutrient vessels is the main cause. However, hemorrhage in the optic nerve and its sheaths, tears in the nerves, edema of nerve further compromising the blood supply in the optic canal portion, vascular spasm, and bony compression of the nerve in cases of fractures of optic canal or clinoid process all may be responsible.

If the blindness is immediate no treatment is of avail. In cases of delayed blindness, even if by a few minutes, unroofing of optic canal might be helpful.[2] Finally, extraocular palsies may accompany the picture in rare instances.[3]

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WALTER MAYER, M.D.
Richmond, Virginia

WHILE attempts at corneal transplantation were initiated more than a century ago, with only an occasional good result and mostly repeated failures, this field of ophthalmology did not come into its own until the 1940's, when the era of corneal transplants started in earnest. In those days eyes were almost impossible to obtain. When one became available, the eye had to be used fresh, with a minimum of delay between enucleation and use in the operating room, or it could be stored for a brief time in a moist chamber in a refrigerator calibrated to a 4° C. temperature.

As more corneal surgeons were trained here and abroad, the need for eyes increased dramatically. Personal appeals to physicians who had dying patients did not bring sufficient eyes for all the transplants that could be performed. One has to remember that during those years there existed a tremendous number of patients who could benefit from a corneal transplant, for there previously had been no form of therapy, and surgeons with dozens of patients waiting for a suitable cornea were the rule.



It soon became apparent that the need existed for a centralized system of obtaining and distributing donated eyes, and so the first Eye Banks were founded. If an eye could not be used locally for whatever reason, an attempt was made to place it with some neighboring Eye Bank. It was the great fortune of these early Eye Banks that most of them became sponsored by Lions Clubs or other civic organizations, whose members managed the offices, fostered publicity, raised money, and handled shipments of eyes.

During these early days, the globes received by the Eye Banks were examined either with the naked eye or by slitlamps. If a globe seemed to have a good cornea, it was kept in a glass jar with a few drops of saline in the bottom, to keep a moist atmosphere, and supplied in this form to the local surgeon. If the eye was to be shipped out of the city to another Eye Bank, the jar was placed in a thermos jug filled with ice and handed to an airline pilot to be flown with him in the cockpit.

Soon the Eye Bank Association of America was founded, in 1962. Its Code of Ethics attempted to establish common guidelines in the techniques of Eye Banking. It also helped communities establish Eye Banks.

During the past 10 years methods have changed considerably. The fresh eyes obtained in the early days could be kept for two to three days only. At times it was impossible to obtain a hospital bed or contact a patient in that brief time, and so vigorous attempts were made to find a way to prolong the life

Dr. Mayer is Surgical Director of the Old Dominion Eye Bank, Richmond.

of the cornea. It had been found that the ultimate transparency of a graft depended on the integrity of the corneal endothelium, the innermost layer of the cornea; the less injury or damage this endothelium sustained from the time of death until its use, the better the chances for ultimate restoration of vision.

Finally, a method was devised to quick-freeze corneas after submersion in solutions of albumin, sucrose, and dymethylsulfoxide. This allowed the preservation of corneas for up to six months at −179° in liquid nitrogen. In many cases these frozen corneas worked just as well as fresh ones, but the critical part of the procedure consisted in the exacting technique of defrosting, which required that the cornea be defrosted in 55 seconds at 60° and be placed inside the recipient eye within 10 minutes.

At last there was developed a storage medium giving a longer life span to the fresh cornea. This is the McCarey-Kaufman medium, a mixture of TC 199 (a tissue culture medium) and Dextran to keep the cornea dehydrated. Corneas in this medium can be kept for up to four days. Their use is no more complicated than that of fresh tissue.



Through these successively improving methods, the Eye Bank technicians were trained and retrained to meet each method's needs and the changing complexities of storing and transporting the eyes. Additionally, the Banks began keeping detailed records, to allow retrospective studies and analysis of results.

Eye Banks also became involved in legislation to allow donation of eye tissue by living donors. This culminated in the passage of the Uniform Donor Act, which has been passed in 50 state legislatures. Eye Banks have sponsored legislation to provide accredited courses so that morticians and technicians can be trained to perform enucleation of pledged eyes.

What about the future? Each and every Eye Bank accepts each and every eye, and help is needed from the medical profession in making the public more aware. Thousands of blind or almost blind persons have been removed from the list of those receiving Aid for the Blind; from a taxpayer's standpoint alone, it makes a great deal of sense to obtain as many eye donations as possible. During the next few years the medium term storage of corneas probably will be improved, so that corneas will be usable for up to 10 days. And Eye Banks no doubt will be involved in further immunological studies relating to rejection problems. Finally, the hope of each and every Eye Bank in the country is to set up a system by which notice of every death occurring in any hospital will be phoned to the Eye Bank at once. The Eye Bank could then contact the physician in charge and remind him that when he requests an autopsy, as is standard procedure in all hospitals, he may also include a word about donating the eyes.

Virginia physicians have the services of two Eye Banks: the Old Dominion Eye Bank, Richmond, (804) 648-0890, and the Eye Bank of Virginia, Roanoke, (703) 345-8823. A collect call from a physician to either of these Eye Banks will be accepted at any time of the day or night.

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Epidemiologic Observations on Suicides in Virginia

George Moore, M.D.
John Buckman, M.D.
Charlottesville, Virginia

SUICIDE was the eighth leading cause of death in 1972[1] for Virginians and has been among the 10 leading causes since 1965. The 697 suicides for 1972 represented a 13.0% increase over the 617 occurring in 1971. The resulting rate, 14.6 per 100,000 population, was the third highest in Virginia records and was higher than the provisional United States rate of 11.7 for 1972.

The significance of these statistics point to suicide as a state public health problem and deserving of epidemiologic attention.

For Virginia, as in past years, suicides were more frequent among whites, with 71.9% involving white males, and 19.4%, white females. A study of the latest (1968) United States suicide figures for white males, age 35-74, reveals that the Virginia rate of 45.0 per 100,000 was 50% higher than the U.S. rate and third highest among the states.

Resident Suicides with Rates per 100,000 Population by Age, Race, and Sex, Virginia, 1972

	Number					Rate				
	Total	White Male	White Female	Nonwhite Male	Nonwhite Female	Total	White Male	White Female	Nonwhite Male	Nonwhite Female
TOTAL	697	501	135	49	12	14.6	26.2	6.9	11.1	2.6
Under 15	2	2				0.1	0.4			
15-24	101	68	14	16	3	11.2	17.9	4.0	18.4	3.5
25-34	107	74	19	12	2	17.0	27.9	7.2	24.5	3.7
35-44	112	72	31	5	4	19.9	31.0	13.2	11.2	7.8
45-54	166	119	37	8	2	30.6	54.1	16.0	17.9	4.2
55-64	115	88	22	4	1	29.3	57.4	13.0	12.2	2.8
65-74	58	49	7	2		24.3	59.2	6.2	10.2	
75 & over	36	29	5	2		26.4	71.4	6.9	20.3	

Almost a fourth of suicide deaths were in the 45-to 54-year age group. This group had a suicide rate of 30.6 per 100,000 population. In every age group except the 15-24 group, white males had a much higher rate than nonwhite males. White females had higher rates than nonwhite females. The highest suicide rate recorded was for white males, 75 years and older: 71.4 per 100,000.

A study of suicide rates by Planning Districts indicates that District Seven (counties of Frederick, Clarke, Page, Shenandoah, Warren, including the City of Winchester) experienced the greatest rate of suicides for total population. Planning District Seven's rate was 28.5 per 100,000 followed by Planning District Four (counties of Floyd, Giles, Montgomery, Pulaski and the City of Radford), 22.1 per 100,000. Planning District Ten's suicide rate (counties of Albemarle, Fluvanna, Greene, Louisa, Nelson and the City of Charlottesville) was 20.9 per 100,000. Planning Districts with low rates were generally those with higher nonwhite populations in the northeastern and southeastern parts of the state. Planning Districts Four, Seven and Ten are located in the western part of the state where the white population is significantly higher. Planning Districts Ten and Four also contain two large state universities with high male populations; however, this factor is without apparent effect since Planning District Seven has a low student population. In plotting district suicide rates for whites over the age of 15, the Winchester suicide death rate became 39.7 per 100,000; the Charlottesville figure, 34.9 per 100,000, and the Radford area, 29.5 per 100,000. Plan-

From the Thomas Jefferson District Health Department and the Department of Psychiatry of the University of Virginia School of Medicine, Charlottesville.

Submitted 6-28-75.

RESIDENT SUICIDES BY MEANS BY RACE AND SEX
VIRGINIA, 1972

	Total	Sex and Race			
		White Male	White Female	Nonwh Male	Nonwh Female
TOTAL	697	501	135	49	12
Firearms and explosives (E955)	440	337	59	38	6
Poisoning by drugs and medicaments (E950.0-E950.3)	79	30	43	2	4
Hanging, strangulation, and suffocation (E953)	74	57	11	6	
Poisonings by gases other than domestic (E952)	53	45	7	1	
Submersions (drownings) (E954)	19	8	8	2	1
Poisonings by other solid and liquid substances (E950.4-E950.9)	11	7	4		
Jumping from high places (E957)	9	7	2		
Cutting and piercing instruments (E956)	7	6	1		
Poisoning by gases in domestic use (E951)	1	1			
Other and unspecified means (E958)	4	3			1

ning District Twenty-two (counties of Accomack and Northampton) also showed a high suicide rate for white males over the age of 15; 32.8 per 100,000.

Firearms and explosives were the implements of self-destruction for 63.1% of all state suicides[2]. Of the 440 deaths by this means, 105 or 23.9% were in the 45-54 age group. This method was used by 67.3% of the 501 white males committing suicide and by 77.6% of the 49 nonwhite males. Poisoning by drugs and medicaments, the second most used method, was responsible for 79 or 11.3% of the total suicides in 1972; 54.4% (43) of these were white females.

The Thomas Jefferson District Department of Health maintains confidential copies of all death certificates, and the authors extracted all resident certificates listing suicide as a cause of death from 1970 through 1974. (For purposes of this study, a resident is a person listed with an address in the city or county, whether permanent or temporary. University students were included in this category.) It was considered that a compilation of a sufficient number of suicide death certificates for one community might lead to more specific identification of the problem. For this analysis, completed suicides reported only for the City of Charlottesville and the County of Albemarle from 1970 through 1974 were studied. The total number of suicides was 89. For statistical purposes, the estimated July, 1972, population was used as a basis for comparison with state data for 1972. The city-county population base, therefore, was 79,400. By race, 68,100 (85.8%) were white, and 11,300 (14.2%) were black. In the same year, 4,764,500 people resided in Virginia, of whom 18.7% were black.

The average suicide rate from the study of 89 death certificates was 22.4 per 100,000. This rate became 24.7 per 100,000 for whites and 8.8 for blacks.

Resident Suicides by Race and Sex
for City-County (1970-74)

	WM	WF	BM	BF	Total
1970	12	4	1	0	17
1971	10	6	3	0	19
1972	12	5	1	0	18
1973	12	3	0	0	15
1974	15	5	0	0	20
Total	61 (68.6%)	23 (25.8%)	5 (5.6%)	0	89

The complete lack of suicides among black females over a five-year period is remarkable. From state rates, we would have expected at least three black female suicides. While 85.8% of the population base is white, 94.4% of suicides occurred among whites. Over 14% of the population is black, and 5.6% of suicides occurred among members of the black race. Suicides in the Charlottesville-Albemarle area may

thus be considered a disorder affecting primarily the white race and especially white males.

Resident Suicides by Sex and Age
for County-City (1970-74)

Ages	Males	Females
15 - 24	17 (25.6%)	2 (8.7%)
25 - 34	7 (10.6%)	5 (21.7%)
35 - 44	6 (9.1%)	6 (26.1%)
45 - 54	13 (19.8%)	7 (30.5%)
55 - 64	8 (12.1%)	2 (8.7%)
65 and over	15 (22.8%)	1 (4.3%)
Total	66 (100.0%)	23 (100.0%)

Among males, three distinct suicide peaks are evident. Almost 70% of male suicides occurred among age groups 15-24 years (25.6%), 45-54 years (19.8%) and 65 years and over (22.8%). It would appear that males, most of whom are white, suffer unusual stresses leading to suicide during these three age periods. Females showed a different pattern, with 78.3% of female suicides occurring during the years 25 through 54. Different stresses would seem to be present among women to create this configuration.

The state suicide rate per 100,000 population for those aged 65 and over was 25.6. From our community study, the actual average annual rate proved to be 28.2. Whereas 8% of the white population for the state was aged 65 and over, 7.4% of the black population was 65 and over. For the city-county, 10.5% of blacks were over 65 and 10.1% of whites were 65 years and over, after adjustment for students was made. Thus, both races showed a higher proportion of older residents locally than did the state as a whole, but the difference in population between the community and the state was greater for blacks. Charlottesville-Albemarle has seen a 13.4% inmigration of whites since 1960 and an outmigration of blacks of about 0.5%.

These comparative observations are important in arriving at postulates, since neither national nor state data can be readily analyzed in the same way. From our local study, we can conclude that age, sex, and race are factors in the causology of suicide only as they pertain to special stresses.

The 89 death certificates were analyzed for other identifying data. One item of interest is the occupation of the deceased.

Resident Suicides By Occupation
for City-County (1970-74)

Professionals	4	4.5%			
Managers & Proprietors	8	9.0%			
Craftsmen & Skilled	11	12.4%			
Unskilled Workers	14	15.7%	21	23.6%	
Unemployed	7	7.9%			
Housewives	14	15.7%			37 41.6%
Military	2	2.2%			
Students - High School	4	4.5%	9	10.1%	
Students - College	5	5.6%			
Retirees under 65	5	5.6%	20	22.5%	
Retirees over 65	15	16.9%			
Total	89	100.0%			

It is clear that suicides respect no occupation. Only 7.9% of the 89 suicides were unemployed at the time of death, with over one-half of the suicides among the unemployed occurring in 1974. Combining unskilled workers and the unemployed presented a significant percentage of suicides (23.6%), and it may be that one stress leading to suicide among unskilled workers is the inability to achieve work security. By combining categories of unskilled workers, unemployed, housewives (listed as usual or last occupation on death certificate), and military, the percentage of suicides increased to 41.6%. This reinforces the observation that suicidal stress is associated with having neither a work skill nor a satisfying avocation, as among some housewives. Student suicides were relatively high (10.1%) but four of the nine student deaths occurred among high school youth. The University of Virginia student population approximates 13,000, yet only five college students committed suicide during the five-year period. By occupation, professionals generally committed suicide after the age of 45; managers, proprietors, craftsmen, and skilled workers between the ages of 25-54; unskilled workers between 15-24 years of age; and the unemployed, 45-65 years. The group of retirees was studied by age, and it was found that five of the 20 re-

tirees committed suicide before they had reached the age of 65. It may be assumed that these retirees were not able to adjust to the early retirement they had apparently chosen for themselves. Retirement itself may present another stress of importance since 22.8% of all suicides occurred among retired persons aged 65 and over.

Among male suicides, 20.7% had never been married, 65.5% were married and 13.8% were either widowed or divorced. The pattern differs somewhat for females; 13.6% had never been married, 77.3% were married, and 9.1% were widowed or divorced.

Marital status of the Charlottesville-Albemarle population as listed in the 1970 census showed 37% single, 57% married, 2% separated, 2% widowed, and 2% divorced males. For females, 22% were single, 59% married, 2% separated, 13% widowed, and 4% divorced. The difference between expected and observed suicides among those separated, widowed, and divorced was significant. The loss of mate for the male resulted in a four-fold increase of suicide risk. The female suicide rate among those who lost a mate was 50% less than expected. Over 75% of females who committed suicide were married (expected rate was 59%). Observed suicide rates for never-married males and females were less than expected. The death certificate, of course, did not disclose at what age a spouse was widowed.

Of the four professionals, three were females near retirement age, and these had never been married. These observations suggest that connubial factors hold a significant role in suicides among females. Among the seven unemployed were three black males, two of whom were married. Unemployment was the major occupational classification for the five black suicides.

The death certificates were studied for medical conditions. Three of the 89 certificates listed chronic disease as a predisposing factor. All of these suicides were among males, aged 54 to 67 years, who suffered from debilitating disorders.

The manner of death was studied by occupation, race and sex. Whereas 74.2% of the 89 suicides used firearms, 82.0% of white males employed this means as compared to 52.0% of white females. Firearms were used almost exclusively by white male professionals, white collar workers, unemployed and unskilled classes. Of the 20 white male retirees, 17 used firearms. Firearms were also used by four of the five blacks. The second most common means of death was poisoning (10.1%). Among white males, most of these suicides occurred among blue collar workers. White females who used poisoning tended to be unemployed or unskilled. Carbon monoxide as a means of death ranked third in the group (6.8%). Most of these occurred among white females. In fact, 35% of all white female suicides occurred either from carbon monoxide or drug poisoning (49% expected). Other means of death for the 89 suicides included hanging (3.4%), jumping from high places (2.2%), drowning (2.2%) and miscellaneous (1.1%). That city-county residents used firearms at a 20% higher rate than shown by state data is of interest. Firearms were used at a uniform annual rate during the period of study.

Only four of the 89 death certificates listed alcoholism as a contributing factor for suicide. Examination of 1972 data for Virginia[2] disclosed that 381 suicidal deaths were autopsied by medical examiners for alcoholic content of blood and 141 (36.7%) showed some trace of alcohol; 77 or 22.2% of these proved to have an alcohol blood level of 150 mgm. per 100 ml or higher at the time of death. In the city-county study, an autopsy was performed on one-third of the 89 suicides, but death certificates did not disclose whether a test for alcohol had been done. It is noteworthy that the four cases of "alcoholism" did not have autopsies performed. Three of these suicides used guns, and one jumped from a high place. The state tables suggest that alcohol ingestion is more associated with homicides (63%) and accidents (53%). While the suicide-alcohol association was 37%, those who were listed as dying from natural causes showed a 25% blood alcohol elevation.

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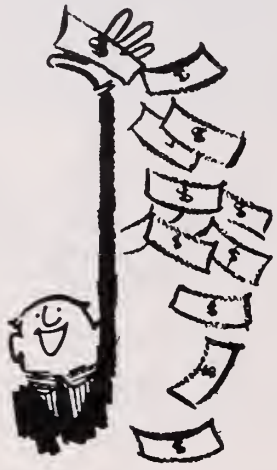
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Of the nine suicides in the study who died from drug poisoning, all were autopsied but none were identified as alcoholics.

All of our 89 suicides were native born Americans except one, a European student. With the exception of the student group, nearly all were long-term residents of this area. Four of the nine students were from out-of-state.

The place of injury was noted from the death certificates, and 68, or 76.4%, of the suicides occurred in or near the usual place of residence, which included bedroom, basement, garage, or driveway. One chose a motel away from home, another a jail, and one killed himself at his usual place of business. Fourteen committed suicide away from their homes in vehicles parked along private or public roads, woods, and parks. Ten of these used firearms. Two of the six deaths from carbon monoxide poisoning also occurred away from home. It is interesting to note that of the 18 suicides away from home, 14 were listed as married at the time of suicide. On the other hand, all but six of the 34 singles (never married, divorced, or widowed) committed suicide at home. One may conclude that a person at suicidal risk usually plans his place of injury carefully. Those who are manifestly depressed but not angry would seem to choose familiar surroundings with privacy. Overtly angry people may choose the time and place of their injury to hurt someone else. This is suggested by the 15 married housewives, who, with two exceptions, injured themselves at home during the hours when their husbands would most likely be near them. A study of times of injury for males as a group indicated no particular time preference.

It appears that January-February and August-September are associated with the highest suicide risk in our area of Virginia. Of all suicides, 44% occurred during these four months. June and October were the months of least frequency. Sunday proved to be the choice day of the week for suicides, followed by Wednesday; 42.7% of suicides occurred over weekends.

Resident Suicides By Day of Week of Injury for City County (1970-74)

Monday	11	12.4%	
Tuesday	9	10.1%	
Wednesday	17	19.1%	
Thursday	5	5.6%	
Friday	9	10.1%	
Saturday	15	16.9%	42.7%
Sunday	23	25.8%	
Total	89	100.0%	

Only two of the 89 suicides occurred on either a national or state holiday (Veterans and Election Days). No suicide occurred on a birthday.

Resident Suicides By Month of Injury for City-County (1970-74)

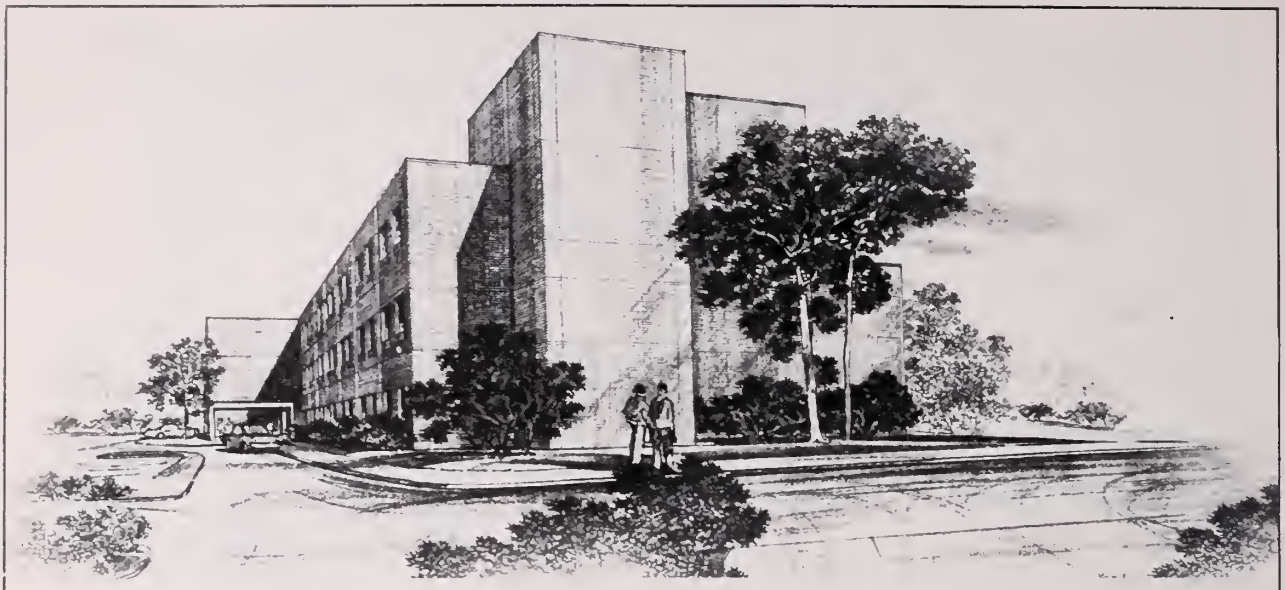
January	10	11.2%	- High	21.3%
February	9	10.1%		
March	6	6.7%		
April	8	9.0%		
May	7	7.9%		
June	3	3.4%	- Low	
July	7	7.9%		
August	10	11.2%	- High	22.4%
September	10	11.2%		
October	4	4.5%	- Low	
November	8	9.0%		
December	7	7.9%		
Total	89	100.0%		

Utilizing means of injury as a method of time study, a significant time pattern occurred among those dying by carbon monoxide poisoning. Almost all of these six deaths occurred during the winter months and on weekends. This was true regardless of age, race, employment, or marital status. This again suggests that suicidal persons tend to plan the manner of their death in advance of the act.

(This is the first part of a two-part article.)

References

1. Virginia State Department of Health: Vital Statistics Monthly Report. Richmond, November 1, 1973
2. Virginia State Department of Health: Statistical Annual Report. Richmond, 1972



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THE NEED FOR OB/GYN REGIONAL PLANNING

Under Public Law 93-641, signed into law by the President on January 4, 1975, the Secretary of Health, Education, and Welfare is required to issue guidelines concerning national health planning policy, these in line with national health planning goals and priorities. To determine priorities, the law set up a network of Health Service Areas (HSA) in each state. The governor of each state was requested to designate these areas. These have been designated for Virginia with boundaries corresponding to PSRO boundaries and including already existing planning districts.

The overall plan for each aspect of medical practice, including ob/gyn, must be written in each Health Service Area in the state. Wise obstetricians/gynecologists will write a plan, in consultation with knowledgeable third parties, that will conform to what is believed to be good ob/gyn practice. This plan should attempt to establish within each region health care facilities functioning at various levels of sophistication. And rather than live with something that is thrust upon them, the ob/gyn profession must develop regional plans for practice of its specialty in terms of resources and population in each HSA.

The state ob/gyn committee should consist of one or two ob/gyn practitioners from each HSA. These physicians must also be the nucleus of the local HSA ob/gyn committee. In addition, one member of the State Health Department, one member of the fetus and newborn committee, one perinatologist or representative from each of the state medical schools, and one health planner should be appointed. Others may be included if appropriate. This committee, unlike its local counterpart, is made up mainly of professionals. Great care must be taken so that the committee includes many disciplines but is not too large to function. Its functions are:

- To study, adopt or modify quality standards for regionalization of obstetric care at all levels.
- To provide a forum to discuss problems in each region and to compare solutions.
- To be a force for the development of new legislation beneficial to maternity patients in Virginia and over the country—a strong voice to speak to legislators on behalf of ob/gyn and its patients.
- To speak as a united voice to influence such programs as Medicaid, Blue Cross/Blue Shield, and federally funded maternal and child health programs in Virginia.

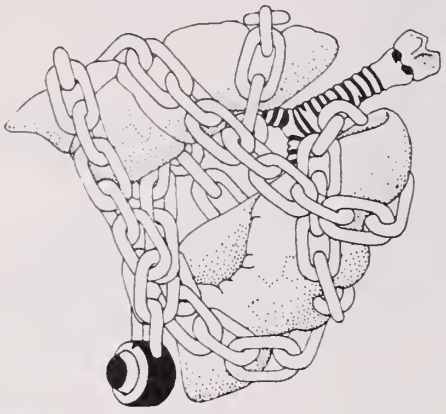
The local HSA ob/gyn committee should do most of the planning, because local people are most acutely aware of the problems facing providers and consumers of ob/gyn services at the local level. The nucleus of the committee is the area obstetrician, who is also a member of the state committee. However, the committee should include as many doctors involved in perinatal care as possible. Many disciplines should be included, such as nurses, health department staff, nutritionists, social workers, welfare workers, PTA's, teachers, health planners, planned parenthood groups—but especially consumers. This increases the likelihood that all types of related problems will be presented for solution.

This planning group should determine local options and develop a plan with an area focus, within the scope of the statewide plan adopted by the state ob/gyn committee. Data must be gathered about population and its distribution, available hospital and medical care services, transportation, resources which are over- and underutilized, demographic and vital statistics, referral patterns, and much more. Plans should indicate the process by which every woman in that planning area will receive access to appropriate high quality perinatal health care. Most important, the public must be kept informed about what is being done to develop grassroots support for this local ob/gyn committee and its plan.

The initiative to improve the outcome of pregnancy must come from the health professions and practicing physicians, through their medical societies and specialty organizations. The physicians must accept major responsibilities in planning and undertaking modifications of existing patterns of practice.

Specific details for initiating action cannot be given for all the differing areas of the state. Just as the regional plans throughout the country will vary, so will the methods of approach for planning, implementation, and evaluation. The paramount importance is leadership and commitment from the medical profession to see that services are organized to provide optimal care to the perinatal patient.

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- ☐ Non-ACEP Physician $175
- ☐ Interns. Residents $100
- ☐ Students ..... $ 50

No refunds will be made unless written notification received by May 22, 1976. (Registration limited to 200 physicians.)

Calendar of Medical Events, 1976

EEG Symposium—Sponsored by Department of Neurology, MCV—Richmond—May 17-18.

Physicians Seminar on Childhood Cancer—Sponsored by American Cancer Society, Fairfax County Unit—Fairfax Hospital Cafetorium—Falls Church—Noon to 4:30 p.m., May 20.

Ninth Annual Lecture Series on Surgery of the Upper Extremity—Sponsored by Department of Continuing Education, MCV—1200 East Clay Street, Richmond—May 20-21.

Annual Spring Forum for Child Psychiatry—Sponsored by Division of Child Psychiatry, MCV, and Virginia Treatment Center for Children—Richmond—May 21.

Clinical Rheumatology for the Practicing Physician—Sponsored by the Virginia Chapter of the Arthritis Foundation, Virginia Regional Medical Program, Medical College of Virginia, University of Virginia School of Medicine, and Eastern Virginia Medical School—Bonhomme Richard Inn, Williamsburg—May 21-22.

Annual Clinical Session—The Virginia Society of Ophthalmology and Otolaryngology—Williamsburg Conference Center—May 26-29.

The 3rd Symposium on Common Pediatric Problems—Sponsored by George Washington University and the Children's Hospital National Medical Center, Washington—Washington—May 27-29.

Pediatric Nephrology for Practicing Physicians—Sponsored by Department of Pediatrics, MCV—Richmond—June 2.

Symposium—Sponsored by the Maryland/Virginia Chapters, American College of Emergency Physicians—Washington, D. C.—June 10-12.

7th INTERNATIONAL CONGRESS OF HYPNOSIS AND PSYCHOSOMATIC MEDICINE. July 1-3, 1976. Sponsored by the University of Pennsylvania. In addition to submitted contributions, a number of major symposia are scheduled. These include: Hypnosis and the Control of Pain; Multiple Personality; Hypnosis and Behavior Therapy; The Hypnotic Treatment of Psychosomatic Disorders; The Use of Hypnosis with Children; Hypnosis in the Treatment of Burns. Participants will have the opportunity not only of hearing many distinguished colleagues present their views formally, but also of meeting in small groups for scheduled informal conversations. For information regarding registration and accommodations, please write to Martin T. Orne, M.D., Ph.D., The Institute of Pennsylvania Hospital, 111 North 49th Street, Philadelphia, PA 19139.

Athletes and MDs: A Course in Charlottesville

"The Art and Science of Sports Medicine, 1976" is the title of a postgraduate course to be offered June 23-26 in Ruffner Hall auditorium at the University of Virginia, Charlottesville. The course is sponsored by the University's Departments of Orthopedic Surgery/Rehabilitation, Health/Physical Education, and Athletics, in cooperation with the Committee on Sports Medicine of the Medical Society of Virginia. Frank C. McCue III, M.D., and Clifford E. Brubaker, Ph.D., are co-chairmen.

The program of speakers is an impressive index of recognized authorities from over the country—physicians, coaches, and trainers—who will address themselves to a comprehensive list of topics, including the injured knee, the upper extremity; tennis, golf, and skiing injuries; the athletic trainer, the female athlete; perspectives on exercise and fitness; and sports medicine for the handicapped. An evening feature will be a panel discussion in which problems and practices in athletics and sports medicine will be addressed by well-known coaches and trainers.

For complete information, contact Dr. McCue, Department of Orthopedics, University of Virginia Medical Center, Charlottesville 22903.

Editorial....

The Open Season on Doctors

HUNTING season on birds and beasts was winding down a month or so ago when the season opened once again on doctors. The hunters on this occasion were Boyce Rensberger and Jane E. Brody of the *New York Times* Service. Their salvo was recorded locally by the *Richmond Times-Dispatch* in a six-column spread at the top of page one, preceded by, "Editor's note: this is the first of five articles exploring the problem of incompetent doctors." Although many of you may not have had the opportunity of following the excitement in your daily gazette, the headlines tell the whole story:

"5% Of Nation's Physicians Believed To Be Unqualified",
"Abundance Of Surgeons Said To Create 'Make-Work' Situation",
"Prescribed Drugs Kill At Least 30,000 Americans Yearly",
"Medicine's Disciplinary Bodies Remain Weak",
"Experts Suggest How To Choose, Evaluate Doctors".

None of the above is new—or even newsworthy. Doctors have been considered fair game for years, and in one form or another, in one of the news media or another, it has all been said before. Five years ago, *Look* magazine, even then in its terminal illness, featured on its front cover, "Why You Can't Get a Doctor", bracketed neatly between "The Peddling of Sex" and "A Car Thief Talks About Stealing Your Car." Three years ago the National Broadcasting Company beamed its biased "documentary" titled, "What Price Health," into millions of homes. Not to be outdone, the Columbia Broadcasting System countered with "Don't Get Sick in America". Incidentally, there was no sequel naming a country or the circumstances recommended for getting sick.

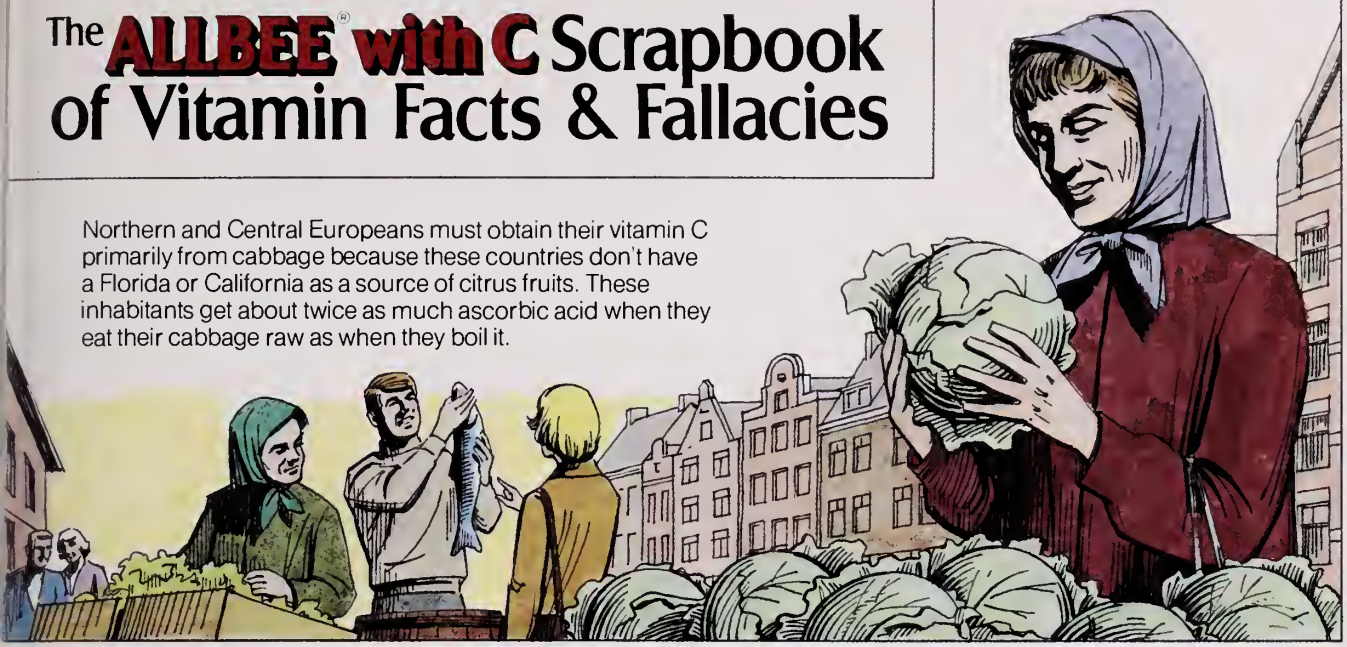
Certainly there is no reason why doctors and the medical profession should not be subjected to careful examination, including harsh criticism. Indeed, criticism, like adversity, may have sweet uses. Medicine does have a problem of incompetent doctors as the editor states. The people of this country, and of every other country, are well advised to consider carefully their choice of physician and to concern themselves with his choice of treatment and its results.

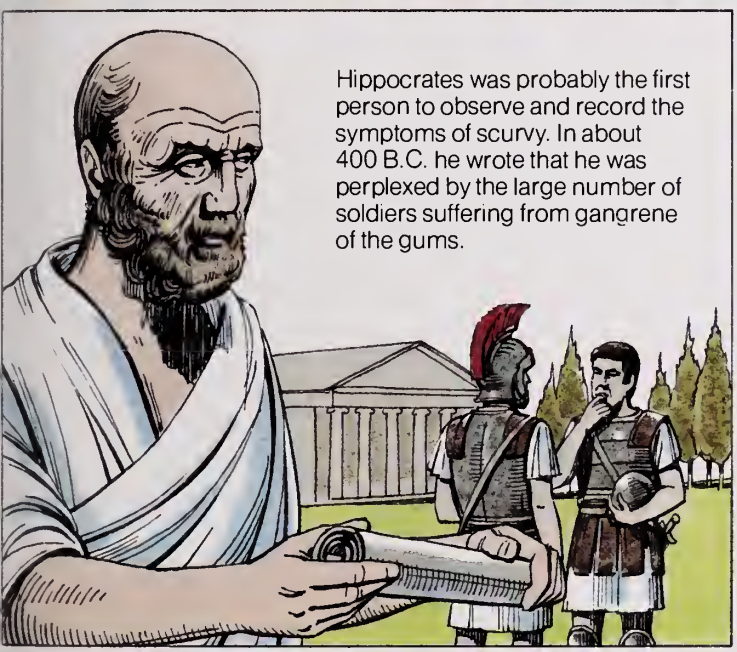
Doctors, as members of the human race, are just ordinary mortals. Treatment failure or harm to the patient may be caused by an honest mistake in judgment, or by lack of competence, or by simple ignorance, or by sheer negligence, or by mean avarice. It is unfortunate that human life, health, and happiness has to be entrusted to fellow humans, but that's the way it is. We do need to be reminded constantly of our problems and our shortcomings.

But is this best accomplished by a six-column front page headline emphasizing 5% of any group? This smacks of overkill, of sensationalism that appeals to the emotions, not the intellect; that creates heat without shedding light; and that often compounds rather than furthers the solution of problems. The obverse of the front page headline is equally true. Rensberger stated plainly that 95% of doctors are believed to be qualified. A truly remarkable figure when one thinks about it. The medical profession, as a whole and com-

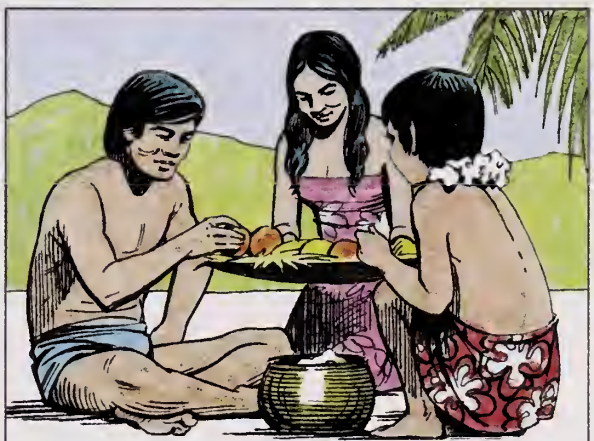
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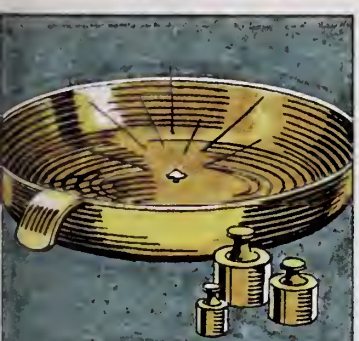




Hippocrates was probably the first person to observe and record the symptoms of scurvy. In about 400 B.C. he wrote that he was perplexed by the large number of soldiers suffering from gangrene of the gums.



People in more primitive, less commercialized societies often eat better balanced diets than affluent Americans. These natives instinctively choose nourishing foods because their bodies tell them what they need. The dietary habits of Americans are often influenced by television commercials that appeal to our wants instead of our needs.



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posed of ordinary humans, rates an A or an A+ in terms of its percentage of qualified practitioners. To my mind, this is much more newsworthy than that 5% of doctors are believed to be incompetent. Calm, reasoned, positive statements don't sell newspapers, however, and it is not surprising that money affects what is considered to be news, and the way it is presented.

To be most useful, criticism should be well-reasoned, fair, and constructive. Rather than attempting to rebut one by one the charges leveled at us and at our profession, let me make some general observations regarding the methods and tenor not only of this series of articles but of others as well. Innuendo, inference, and overkill are standard tactics. One is reminded of the maxim: a half-truth is like a half-brick; you can throw it further.

Selective quotations or quotations out of context are used. The "authorities" chosen are those whose viewpoint supports the subject matter as written. There is no debate, and no space given to equally authoritative statements that express a different opinion.

Examples are cited of frightful developments following surgery or drug treatment with the implication that these results are the rule rather than the exception. There is no real recognition of the often imponderable role that any treatment may play in the course of any illness. In many instances it is not possible to ascertain with any certainty whether there was a causal or simply a temporal relationship between what was done and what developed.

Extrapolation of numbers is a standard method of using statistics to "prove" a point without substantiating it. Extending the findings in a small series of cases to the national population level is always suspect. When the series is also likely to be biased and skewed, using extrapolation as fact is totally unjustified.

No harm is really done by this type of journalism, although in these troubled times we need to emphasize the positive, to criticize calmly and factually, and to be quite precise when pointing out alleged shortcomings of an important segment of our society. Those who are swayed by these kinds of examples, statistics, and reasonings are probably already leaning towards or have joined the activist anti-medical establishment, and are calling for radical changes in the organization and delivery of medical care.

Is the following question a manifestation of paranoia, or is it striking at the truth: Why this series at this time? In our era of propaganda and news manipulation, when articles such as these appear one almost automatically looks for ulterior motives behind the manifest content. Is this a trial balloon to test and/or influence the consensus of the taxpayer and voter regarding the state of American medicine? Is this the initial phase of a campaign to establish national health insurance as a major issue in the impending primaries and elections by claiming to document serious inadequacies in medical care and its delivery? Is an increasingly strong government role to be touted as essential for the rehabilitation of the medical profession and for the protection of the American citizen?

Dr. Hunter H. McGuire, Jr. responded to the newspaper articles by a most constructive letter published in the Voice of the People section of the *Richmond Times-Dispatch*. Because the points he makes have real interest and relevance for our readers, the letter is reprinted in the Point of View department that leads this issue.

W.T.T.



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

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Obituary . . . .

Connie Chua Brumbelow, M.D.
Richmond

At 37 years of age, Dr. Connie Chua Brumbelow died April 3 in Richmond of injuries received in an automobile accident. An anesthesiologist, Dr. Brumbelow had served at hospitals in Roanoke and had taught at the University of Florida before joining the staff of the Medical College of Virginia, Richmond, two years ago as assistant professor of anesthesia. She is survived by her husband and two children.

William E. Daner, M.D.
Richmond

At the age of 61 years, Dr. Williams E. Daner died March 10 in Richmond. An orthopedic surgeon, Dr. Daner was a graduate of the Medical College of Virginia and was a major in the Army Medical Corps during World War II. He had belonged to the Medical Society of Virginia 27 years.

James F. Parkinson, Jr., M.D.
Chester

At the age of 61 years, Dr. James F. Parkinson, Jr., died April 7 in a Chester hospital. Dr. Parkinson was born in Alexandria and was graduated from the Medical College of Virginia, Richmond. He had been a general practitioner in Chester since 1940 and was a medical staff member at Chippenham Hospital, Richmond. His wife, a son, and a daughter survive him.

George Grover Snarr
Winchester

At the age of 86 years, Dr. George Grover Snarr died November 10, 1975, in Winchester. Dr. Snarr was a graduate of the North Carolina Medical College, a practicing ophthalmologist, and a member of The Medical Society of Virginia for over 50 years.

Gordon Bennett Tayloe, M.D.
Norfolk

Retired Rear Admiral Gordon Bennett Tayloe of Norfolk died March 4 in Chowan County, North Carolina, at the age of 77 years.

A native North Carolinian, Dr. Tayloe was graduated from the University of Maryland Medical School and then began 31 years of service with the Navy. During World War II he was senior medical officer with the Sino-American Cooperative Association in China, supervising the care of American officers and enlisted men, as well as an army of Chinese guerillas, in China, India, Burma; it was said that while he held this command, not a man was lost to the many diseases prevalent in the area. After the war he became commanding officer of the Portsmouth Naval Hospital and subsequently held a similar post at Bethesda Naval Hospital. Following his retirement from the navy, he joined the Norfolk County Health Department, becoming health director in 1964.

He is survived by his wife and two sons, one of whom, Gordon B. Tayloe, Jr., is city attorney of Portsmouth.

Jesse Miller Tucker, Jr., M.D.
Huddleston

Dr. Jesse Miller Tucker, who practiced orthopedic surgery in Huddleston for 24 years, died March 14 at the age of 53 years. Dr. Huddleston graduated from the University of Virginia and the Medical College of Virginia. He was a veteran of World War II and had belonged to the Medical Society of Virginia for 23 years.

Your help in making this listing comprehensive and current will be very much appreciated. Please address news of the deaths of members to the Managing Editor, 4205 Dover Road, Richmond VA 23221.

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(*Continued from page 340, Ultrasound/Lawson.*)

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News . . . .

5th District Physicians Propose a Presidential Candidate

On behalf of physicians of the 5th District, Dr. Girard V. Thompson, MSV Councilor, writes to the *Virginia Medical Monthly* requesting the announcement of the candidacy of Dr. W. J. (Bill) Hagood for the office of president-elect of The Medical Society of Virginia.

Dr. Hagood is well known to the membership through his services to many medical organizations and his accomplishments in his specialities, industrial medicine and family practice. He is currently Speaker of the House of the Society's House of Delegates, president of the Virginia Academy of Family Physicians, and a member of the board of directors of the American Academy of Family Physicians. A native Virginian, Dr. Hagood lives in Clover, Virginia.

Dr. Kenley Confirmed as New Health Commissioner

Virginia's sixth health commissioner will be Dr. James B. Kenley, who will accede to the post when Dr. Mack I. Shanholtz retires June 30. His appointment by Gov. Mills E. Godwin, Jr., confirmed the recommendation of a special committee.

Dr. Kenley is a native of Portsmouth and has been deputy health commissioner since 1973. He has been with the health department for about 20 years, first as a local health director and then successively as director of the epidemiology bureau, the division of specialized medical services, and the division of medical and hospital services.

The agency Dr. Kenley will head employs approximately 4,000 persons throughout the state. It is the third largest state agency; only the education and highway departments are larger.

Honors for Dr. Baker, Dr. Moss, and Dr. Fink

Dr. James P. Baker, Norfolk, has been awarded the Virginia Lung Association's 1976 Douglas Southall Freeman Award for "his influential role in bettering the quality of care for Virginians suffering with chronic lung disease." Dr. Baker is director of the pulmonary disease section and professor of internal medicine at Eastern Virginia Medical School. In his work with pulmo-

nary disease Dr. Baker follows a family tradition, for in 1909 his grandfather, Capt. W. W. Baker of Chesterfield County, helped establish the Virginia Anti-Tuberculosis Association (now the Virginia Lung Association) and was its first president.

* * * * *

Dr. James M. Moss, Alexandria, was the recipient of the Distinguished Internist of the Year Award by the Virginia Society of Internal Medicine at its meeting earlier this year in Charlottesville. Dr. Moss is chairman of the AMA's Scientific Exhibit Committee and also heads the Pharmaceutical Committee of the American Society of Internal Medicine. He is a member of the Virginia Health Manpower Commission.

* * * * *

Dr. H. William Fink, Norfolk, is the new chairman of the state chapter of the American Academy of Pediatrics and the Virginia Pediatric Society. He was elected for a three-year term at the annual meeting in Williamsburg.

Authors and Speakers At Home and Abroad

Dr. Lazar J. Greenfield's article , "Assessment of Operability in Carcinoma of the Lung," which appeared in the November, 1975, issue of the *Virginia Medical Monthly*, is to be reprinted in abridged form in the June issue of *RN*, the national magazine for nurses. Dr. Greenfield is professor and chairman of the Department of Surgery, Medical College of Virginia.

* * * * *

The *Richmond News-Leader* has been given permission to reprint the commentary of Dr. Eugene Reyes Perez that appeared in our March issue, titled "The Need for Integrity," and to the Bibliotheque Universitaire in Brest, France, in answer to its request, we have forwarded a copy of Dr. Christian V. Cimmino's article in the April, 1967, issue, "Some Radio-Diagnostic Notes on Pneumomediastinum, Pneumothorax, and Pneumopericardium."

* * * * *

Dr. James L. Mathis, Richmond, is the author of "Marriage in a Changing Society," an article that appeared recently in *Southern Medicine*, the bimonthly published by the Southern Medical Association.

Dr. Mathis terms our culture "one of the most 'married' in the world," estimating that about 95% of American adults marry at least one time.

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He discusses these factors presently operating to alter the functions of marriage in our society: the change from extended to nuclear family units; the redefinition of masculinity and femininity; the sexual and economic quality of today's female; the declining value of the role of housewife and concomitant devaluation of child rearing; the abdication of parental rights and responsibilities; the effects of affluence; the changing attitude towards divorce; the mobility of family units. He expects the medical profession to become more and more involved as these factors effect changes in marriage as a social institution, for, he points out, a system in process of change is more vulnerable to stress. He concludes that competent diagnosis and proper guidance will require of the physician an understanding of these changes as they occur.

Dr. Mathis is professor and chairman of the Department of Psychiatry, Medical College of Virginia. On July 1 he will move to Greenville, North Carolina, where he will assume the chairmanship of the Department of Psychiatry at the East Carolina School of Medicine.

* * * * *

Dr. Gwo-Jaw Wang and Dr. Roby C. Thompson, Charlottesville, are authors of an article published recently in the *Southern Medical Journal* titled "Treatment of Aseptic Necrosis of the Femoral Head with Phemister-type Bone Grafts." Dr. Wang and Dr. Thompson studied 10 patients (11 hips) with a minimum of two years follow-up, evaluating them by radiographic and clinical parameters. Seven of the 11 hips had good or excellent results; they describe the criteria for a successful result as proper patient selection and exact placement of the bone grafts. The Phemister bone grafts appeared to the authors to be the treatment of choice in early aseptic necrosis of the femoral head.

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A quartet of Virginia physicians appeared as authors in a recent issue of the *New England Journal of Medicine*. They are Dr. Herschel L. Estep, Dr. Edward W. Moore, Dr. Giles M. Robertson, Jr., and Dr. Donald M. Switz, all of Richmond. Their article is entitled, "Inadequate Parathyroid Response in Acute Pancreatitis," and they were joined in the study by Dr. Glen W. Sizemore of the Mayo Clinic.

The abstract reads, "We studied nine consecutive hypocalcemic patients with acute pancreatitis to elucidate the mechanism of hypocalcemia. . . . These findings suggest that neither glucagon nor calcitonin was primarily responsible for the hypocalcemia, which did not produce expected increases in serum parathyroid hormone concentrations. Relative parathryoid insufficiency may account for the persistent hypocalcemia frequently observed in patients with acute pancreatitis."

An editorial in the same issue comments, "The current study used electrode measurement of serum ionized calcium—a recent advance in the investigation of calcium disorders. . . . The potential importance of this new technic is yet to be fully recognized and will undoubtedly be instrumental in the investigation of calcium disorders in the future."

For reprints: Dr. Moore, Box 908, MCV Station, Medical College of Virginia, Richmond VA 23298.

* * * * *

Dr. Harry Pariser, professor of microbiology and cell biology at Eastern Virginia Medical School and director of the Norfolk City Venereal Disease program, was a speaker at a recent conference on sexually transmitted diseases sponsored in New York City by the New York Academy of Medicine. The central position of Dr. Pariser's speech, as reported in *Ob/Gyn News*, was that physicians should follow the therapeutic regimen recommended by the Center for Disease Control in treating gonorrhea and syphilis. The features that make the CDC treatment schedule worthwhile, Dr. Pariser said, are that it is based on

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efficacy results obtained in large-scale, controlled studies and is constantly reevaluated and revised.

Dr. Pariser cited the Center for Disease Control's recommended dosage of 4.8 million units of penicillin IM, given in at least two doses at one visit, preceded by 1 g of probenecid orally. This, he said, will probably remain the treatment of choice for gonorrhea for several years, even though it is not effective in all cases due to penicillin resistant strains of *Neisseria gonorrhoeae.* The degree of resistance, Dr. Pariser pointed out, is not absolute and appears to be leveling off.

Dr. Pariser is reported as advocating the treatment of sexual partner or partners of the gonorrhea patient even in the absence of symptoms and positive laboratory results. He recommended one followup culture for men, two for women.

The CDC treatment schedule for syphilis, 2.4 million units of benzathine penicillin G, half in each buttock at one visit, cure 90-95% of the cases of early disease, according to Dr. Pariser. The recommended dosage for late syphilis of 6-9 million units of benzathine penicillin G, given in weekly doses of 3 million units, may need reevaluation, he warned, because there are several published reports indicating progression of the disease with these doses.

* * * * *

These guest speakers are slated for the meeting of the Virginia Society of Ophthalmology and Otolaryngology May 26-29 at Williamsburg: G. Jan Beekhuis, M.D., Detroit, "Correction of the Deviated Nose and Saddle Nose Deformity", Richard R. Gacek, M.D., Worcester, Massachusetts, "Management of Carcinoma of Temporal Bone Technique and Results of Tympanoplasty Types 3, 4, and 5"; Arthur Jampolsky, M.D., San Francisco, "Infantile Esotropia—Some Recent Concepts, Adjustable Strabismus Surgical Techniques"; Maurice B. Landers III, M.D., Durham, "Vitrectomy 1976, the Argon Laser: Its Use and Misuse."

* * * * *

Speakers will address aspects of "The Hyperactive Child: Research Perspectives and Clinical Applications" at the Interdisciplinary Symposium on June 2-3 in Charlottesville. The psychology department of the Children's Rehabilitation Center, University of Virginia, is the sponsor. For information write Dr. R. H. Willoughby, Route 250 West, Charlottesville VA 22901.

* * * *

The Fifth Edition of the "Foreign Travel Immunization Guide 1976" is now available, according to a communication from Hans H. Neumann, M.D., Director of Preventive Medicine for the Department of Health, New Haven, Connecticut. It is a fine little booklet, its information concisely presented, handily indexed, and covered in vivid yellow so that it may more easily be found amongst a physician's reference works. For your copy, address Box 611, New Haven CONN 06503, and enclose a check for $2.50.

Richmond's Medical Heritage: A Long View

Salient contributions to the Virginia medical tradition are recounted in "Medicine in Richmond, 1900-1975," written by Dr. Charles M. Caravati and published by the Richmond Academy of Medicine. Dr. Caravati has a long view of Virginia's medical history, for he has practiced gastroenterology in Richmond for almost 50 years. He scrupulously documents the city's physicians and hospitals; describes the large role of medical education in Virginia's capital; reviews the medical publications of the area, including the early days of the *Virginia Medical Monthly;* details the evolution of the Richmond Academy of Medicine; and with scholarly care writes of other major aspects of Richmond's medical life over the years.

The book's illustrations include this nostalgic drawing of the Old Dominion Hospital, once part of the Medical College of Virginia in downtown Richmond. Established in 1838, it moved



to the building shown in 1861, where its 75 beds were kept filled by Confederate casualties during the ensuing years of the Civil War. It was demolished to make way for the MCV dormitory now standing in its place; but if plans for the big new MCV hospital materialize, a hospital will once again occupy the site.

Orders for the book are being filled by the Richmond Academy of Medicine, 1200 East Clay Street, Richmond VA 23219. The price is $8.50.

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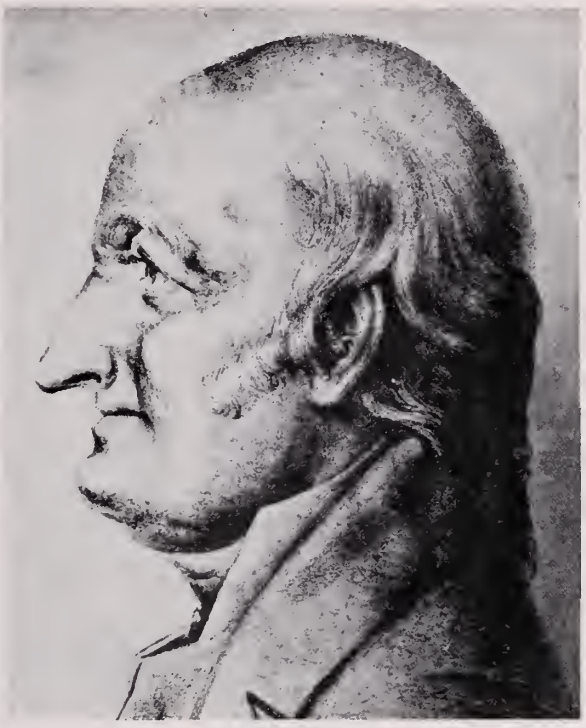
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The Hampton Medical Society has memorialized Dr. James McClurg, distinguished Virginia physician and patriot, with the donation of a bronze plaque to the Hampton General Hospital.

As the plaque attests, Dr. McClurg was born in Hampton in 1747, the son of an English army



surgeon stationed there. After studying in Scotland, Paris, and England, he returned to Virginia and set up medical practice in Williamsburg in 1773. When the Chair of Anatomy and Medicine was created at the College of William and Mary, he was appointed as its first professor. He served in the Revolutionary Army, was "superintendent and inspector of hospitals in Virginia" after the war, and as a member of the Constitutional Convention in Philadelphia in 1787 took an influential part in drafting the Constitution. He moved to Richmond in 1783, where he became the first president of The Virginia Medical Society and was three times elected mayor. Dr. McClurg died in 1823, at 77 years of age, and is buried in St. John's churchyard in Richmond.

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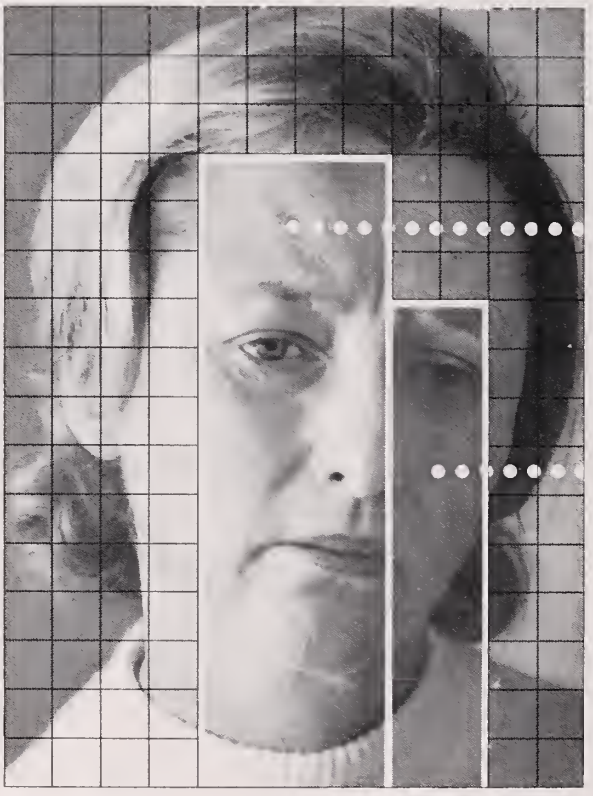
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ANN GRAY, *Managing Editor*

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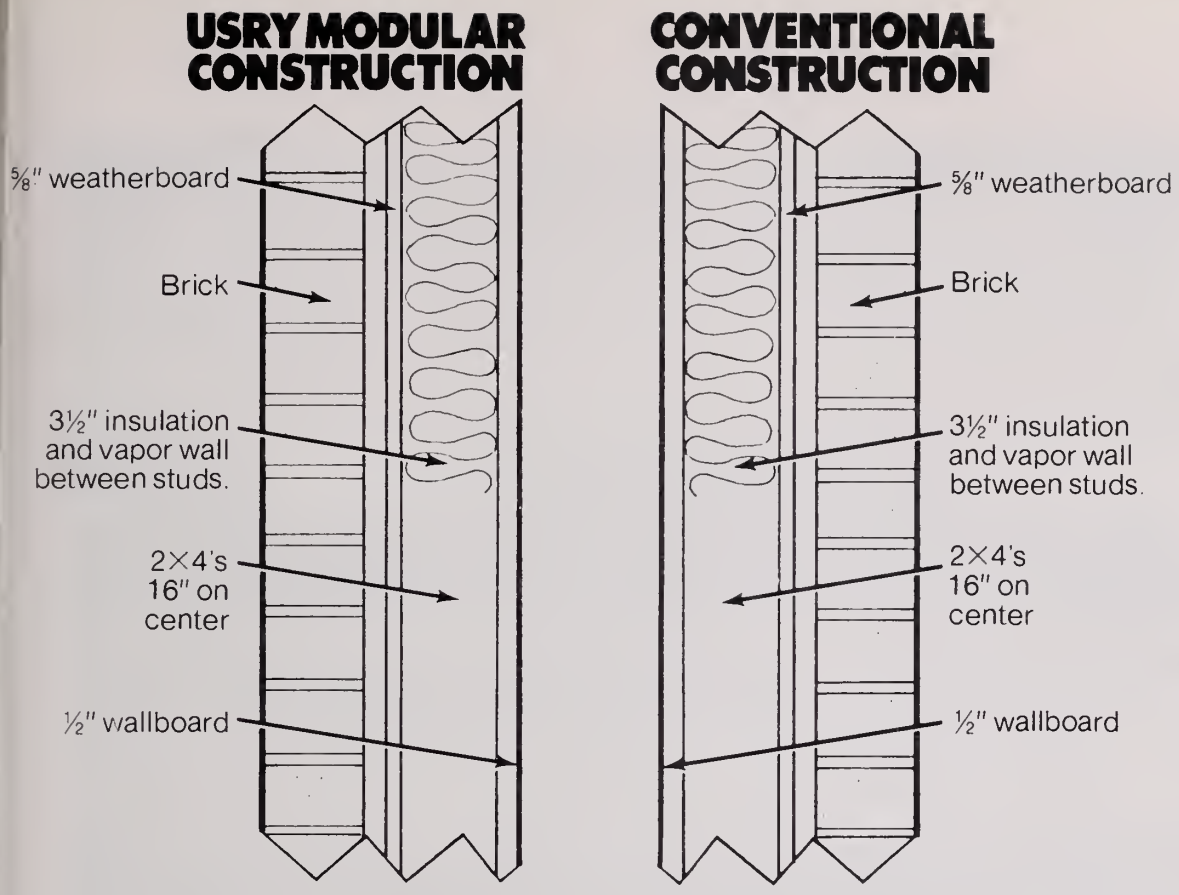
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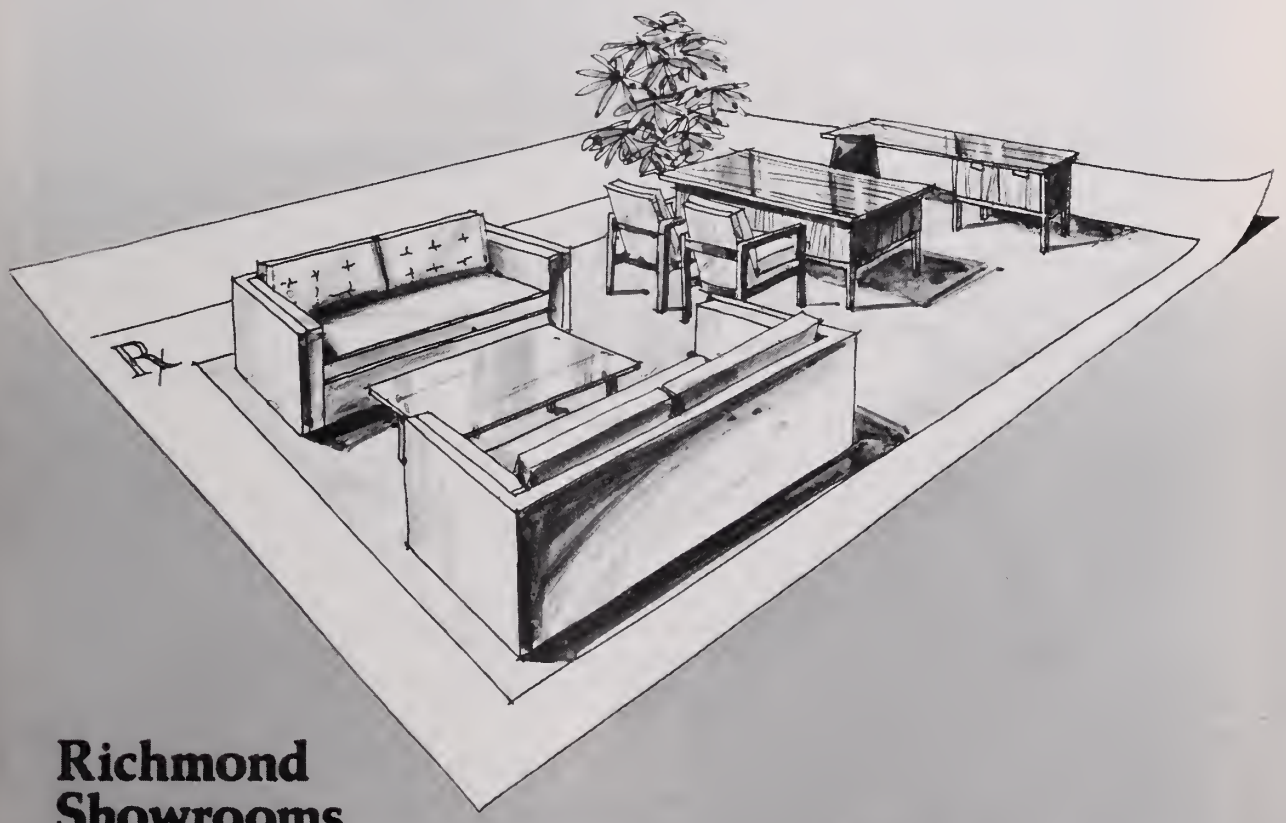
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Point of View . . . .

A Physician Finds Lobbying an "Eye-Opener"

RECENTLY I was exposed to a most interesting and yet very disappointing experience, one which I feel would be worth sharing with all members of The Medical Society of Virginia. For five weeks I was a registered lobbyist at the 1976 session of the Virginia General Assembly.

My usual profession is an anesthesiologist in Alexandria. Since my specialty is classified as "high risk" for malpractice insurance, I became quite concerned and involved in the problem of rapidly escalating insurance rates. Soon I found myself chairman of the Alexandria Medical Society's Malpractice Committee, and deeply involved in the campaign for passage of adequate malpractice legislation.

When the legislature met and began consideration of the several bills which were introduced, I made a trip to Richmond to see how they would be received. My first attendance at a Senate subcommittee, which was considering two of the comprehensive malpractice bills, was a real eye-opener. Instead of a large body of senators there were only two, plus an assortment of four or five lobbyists, two or three attorneys, and the Insurance Commissioner. One of the bills was killed with no discussion, and the second was systematically gutted until only two provisions of the original bill remained and the more important of those had been substantially altered. This was the form in which it passed thru the senate Courts of Justice Committee and thence to the Senate floor for a vote.

This is apparently the manner in which most legislation is handled. Most of the adding, deleting and altering is done in these small groups, and it is here that one can probably be most effective in influencing the final form of a bill. One needs to be ever present to explain, defend, or offer compromises as each provision is discussed.

My interest had been sharply whetted, and with the indulgence of my five partners and the sponsorship of the Alexandria Society, I remained in Richmond for the remaining five weeks of the 1976 session. My wife also became deeply involved, and we soon joined the group at the capitol working for the State Medical Society, which consisted of Mr. William Miller, our attorney; Mr. Willard Osburn, our lobbyist; Miss Mary Beth Taliaferro, a legislative interne from Duke University; and Mr. Gary Miller, a fourth year medical student from MCV. At especially crucial times we were also joined by our president, Dr. Raymond Brown, and our executive vice-president, Mr. Robert Howard.

In the innumerable meetings which followed on days, nights, and even weekends, we managed to always have at least one and usually several of our group present. The committee and subcommittee meetings were the most difficult, as various of our bills often would be under consideration in different places at the same time.

Of all the bills relating to the malpractice insurance problem which were introduced,

only two survived. One of these, the joint underwriting association as proposed by Insurance Commissioner Day, passed with little opposition. The other, Senate Bill 115, had an extremely stormy history, with numerous amendments added and deleted on both the House and Senate sides. It finally ended up in a joint conference committee of the House and Senate on the last night of the session. The again-altered version which emerged narrowly missed being killed by a last minute parliamentary maneuver in the House but was finally passed by both House and Senate. The remainder of the numerous malpractice bills were either killed or carried over to the 1977 session.

". . . the medical profession could become a very powerful force in molding public opinion."

I will not attempt to analyze or explain the final bill, for I'm sure you will read of it many times in the ensuing months. My only comment is that it is much less than we had hoped for and is not likely to have any beneficial effect on malpractice insurance rates in the near future, but it does represent an initial step on which we must build.

Most physicians have no interest in politics, and until recently I was no exception. We have preferred to become immersed in our medical books, our practices, and our private lives, and to tell ourselves and others that we have no time for political activities. As much as this may appeal to us, we can no longer afford this attitude.

Whether we like it or not, medicine is and will continue to be increasingly affected by the actions of politicians. If we are not to lose control of our own profession then we must exercise some control over political events. Remember that physicians have tremendous access to the public, and if each of us would take a little time to acquaint his patients with the issues for which we need support, the medical profession could become a very powerful force in molding public opinion.

Very few legislators have the courage to ignore an overwhelming demand by the general public. This was adequately demonstrated during the recent session. Those who represented the few areas in which the medical societies had mounted an intensive campaign for public support were far more receptive to our bills than were those in which this public support was absent. Unfortunately the areas of relative apathy were predominant.

Each physician must become involved if we are to succeed next year and thereafter. The time to start this campaign is now and it must continue. I have the utmost respect for Mr. Howard, Mr. Miller, and Mr. Osburn, whom we employ to operate and represent our state Society. However, we have no right to expect them to do everything, while most of us do little or nothing. We need an active organization of physicians to support their efforts and be available to them, not on a periodic but on a continuous basis. This will of course require much more time and effort from each of us, but if we do it effectively, I feel sure we will all be pleased with the results.

"If we are not to lose control of our profession, we must exercise some control over political events."

Jack R. Woodside, M.D.

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A committee of Michigan MDs assails the insurance industry, page 463.
The malpractice infection spreads to the law, page 464.

How To Be a Better Lobbyist

These pointers on effective lobbying appeared recently in the journal of the Michigan State Medical Society, Michigan Medicine, *whose editors have given permission for this reprinting. They were formulated by Gene Dyson, president of the Georgia Business and Industry Association, in a talk at a recent MDPAC workshop for Michigan physicians, and display unusual insight and practicality.*

(1) Reach a concensus among your members on issues, then go forth to do battle in the legislative arena united—otherwise, you'll get picked off one by one.

(2) Go to the pros—your professional staff members and others with credentials—rather than relying on news media or politicians for your information and strategy.

(3) Get to know your legislators, their backgrounds, motivations, intelligence, personalities, legislative records, even their closest neighbors on Senate and House floors, who can have a major influence on how they vote.

(4) Meet and get to know all new members of the legislature.

(5) Get your friends registered to vote, particularly those who feel as you do on vital issues.

(6) Know the two major rules of politics—namely, that politicians must get re-elected, and that "politics is the art of compromise."

(7) Use television, as it is the source of most Americans' opinions.

(8) Describe your issues in terms of the public good and not in your own self interest. Explain your views' advantages to your constituents.

(9) Find a way to be sure that you have communicated with your legislators, to make sure that they receive your message.

(10) Adjust for new developments and prepare alternative plans for changing situations.

(11) Help the governor, as he can sponsor your legislation and veto bills you don't approve.

(12) If you are testifying, then you should know all there is to know about the committee members you are addressing: be precise and careful, and be sure your friends are present as you testify. Also be prepared for loaded questions, and don't answer, "I don't know." Instead answer "I'll get that answer for you." When testifying, give out printed copies of your remarks, so you won't be misquoted by the news media; and be prepared to meet the press after testifying and stand by your statement in testimony.

(13) Know the resources for information available to you and your legislators.

(14) Remember that lobbying is hard work, but you are living in jeopardy if you don't devote some part of your life to government.

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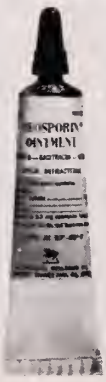
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Medicine and the Virginia Legislature, 1976

FROM a medical point of view, the 1976 session of the Virginia General Assembly was one of the most important in the history of the Commonwealth. Of a total of 2,089 bills and resolutions introduced, 194 had medical implications, and 11 were specifically concerned with malpractice.

The membership is to be congratulated on its assistance in getting Bill SB-115 passed by the General Assembly. Those members who contacted their legislators directly are to be especially commended. Each letter, telegram, and telephone call made a difference!

It would be highly politic for all members to send personal thanks to members of the General Assembly for making the passage of this bill possible. A note of appreciation would be most appropriate. Your local medical society has the names of the legislators from your district.

Here are the bills of particular importance.

Society Malpractice Bill

HB 190 (Pendleton)—*Supported. Carried over to 1977.* This bill incorporates all of the provisions set forth by the Society's House of Delegates bill. It includes the (1) $500,000 limitation of recovery, (2) the six-year statute of limitation reduction for minors, (3) establishes patient's compensation fund, (4) calls for the 15% limitation on attorney fees for any recovery from patients' compensation fund, (5) establishes the Residual Malpractice Insurance Authority and (6) the medical review panel. Although the original bill did not conform exactly to the Society's bill, amendments were prepared to make the necessary changes.

Joint Underwriting Association

SB-112 (Willey)—*Supported. Enacted.* Relates to the creation of a medical malpractice Joint Underwriting Association (JUA).

Malpractice Bill

SB-114 (Mitchell)—*Supported. Killed.* This bill closely resembled the Society's original bill. The two basic differences were placing the statute of limitations for minors at 12 years and creating an assigned risk program to replace the Residual Insurance Authority.

Ad Damnum Clause

SB-125 (Willey)—*Supported. Killed.* "No dollar amount or figure shall be included in the demand for relief in any motion for judgment in any action for damages or personal injury or death, but the demand shall be for such damages as are reasonable in the premises."

Malpractice Bill

SB-115 (Fears)—*Supported. Enacted.* This bill provides for: (1) a $750,000 limitation of total awards; (2) immunity provisions for medical staff review committees; (3) a medical screening panel consisting of three health care providers, three attorneys and one circuit court judge; (4) binding arbitration to be considered if both parties and insurance companies agree. Effective date of $750,000 limitation, April 1, 1977. Challenge of constitutionality of the limitation of awards is anticipated; therefore the delay in the effective date of the cap. The remainder of the bill will become effective July 1, 1976.

Medical Malpractice Review Panel

SB-131 (Willey)—*Supported. Killed.* Related to review of medical malpractice claims against health care providers by medical review panels. The panel makeup was composed of five members: two attorneys, one a member of the public, and two health care providers.

Collateral Sources

SB-119 (Willey)—*Supported. Killed.* "In any action for damages for personal injury or death where it is alleged that the plaintiff or decedent suffered economic loss by reason of such injury or death, including but not limited to the cost of medical care, custodial care or rehabilitation services, loss of services, and loss of earned income, evidence shall be admissible that any such cost or expense was paid for or payable by, or any such economic loss was replaced or indemnified, in whole or in part, by insurance or governmental, employment or service benefit programs."

Joint Committee Malpractice Study

HJR-14 (Pendleton)—*No Position. Killed.* Provided for a Joint Committee of the House Committee on Health, Welfare and Institutions and the Senate Committee on Education and Health to conduct a study on medical malpractice insurance and to monitor any problems which presently exist in the State in this field. The Committee was authorized to hire a consultant to aid in the study and funds were requested. An interim report was to have been made by December 15, 1976, and a final report by December 15, 1977.

Joint Subcommittee Malpractice Study

SJR-80 (Bateman)—*Supported. Enacted.* Provides for four subcommittees, consisting of three members each from (1) Senate Courts of Justice, (2) Senate Commerce and Labor, (3) House Courts of Justice and (4) House Corporations, Insurance and Banking Committees, to study the methods and feasibility of spreading the actuarial risks of malpractice insurance for health care providers, the feasibility of deductible provisions in such policies, and other means and methods which might eliminate or mitigate this serious problem. The Subcommittee shall elect its own chairman, and may elect no more than six citizen advisors as members of the Subcommittee. Study to be completed and recommendations reported by December 1, 1976.

Medical Malpractice Panel

SB-396 (Michael)—*Supported. Killed.* Provided for the establishment of a mandatory medical malpractice review panel consisting of three physicians and three attorneys.

Periodic Payments

HB-1147 (Pickett)—*Supported. Carried over to 1977.* Provides for periodic payments incorporated in medical malpractice judgment orders.

Society Malpractice Bill

HB-1212 (Marshall and Pendleton)—*Supported. Killed.* This bill was amended in the nature of a substitute to provide for the provisions of HB-190 and included: (1) legislative findings of need for bill; (2) statute of frauds—results guaranteed in writing only; (3) elimination of the ad damnum clause; (4) $500,000 limitation of recovery; (5) $250,000 limitation on pain and suffering; (6) statute of limitations for minors reduced to six plus two (eight) years; (7) schedule of maximum contingent fees for malpractice actions to be promulgated by the Supreme Court of Virginia; (8) assigned risk plan to be implemented if there is to be no JUA; (9) medical review panel consisting of three attorneys, three health care providers, and one retired or sitting judge; (10) either party may call for a panel hearing; (11) both parties can request arbitration.

Voluntary Drug Formulary

SB-109 (DuVal)—*Opposed. Carried over to 1977.* Provides for the creation of a voluntary formulary of equivalent drugs with an appropriation of $20,000 thereof.

Voluntary Drug Formulary

HB-205 (Glasscock)—*Opposed. Enacted.* Provides for the use of a formulary of another state or an agency of the United States; a physician must, in his own handwriting, write "voluntary formulary" or "V.F." on a prescription for substitution to take place, and the pharmacist shall notify the practitioner in writing within 48 hours that he has dispensed a drug other than that prescribed.

Impaired Drivers

SB-141 (Truban)—*No Position. Carried over to 1977.* Provides for physicians to report to the State Department of Health any information concerning a patient which would lead him to believe that the patient was physically or mentally incapable of safely operating a motor vehicle on Virginia highways. Such information shall not be considered privileged.

Optometry Price Advertising

SB-145 (Holland)—*No Position. Vetoed.* Repealed the section of the statute prohibiting the advertising by optometrists of price for professional services or for eyeglasses, spectacles, lenses, frames, mountings or any other prosthetic devices.

Uniform Alcoholism Bill

SB-149 (Edmunds)—*No Position. Enacted.* The bill, as originally introduced, would have created a Virginia Advisory Council on alcohol problems and an interdepartmental coordinating committee, and would have provided for emergency committee of alcoholics. The bill also removed the reference to addiction to alcohol. The substitute bill does not appear to abolish the

"We Must Encourage More Physicians to Seek Public Office"

Of its 140 members, the Virginia General Assembly has 83 lawyer-legislators—and only one physician-legislator. He is Senator John C. Buchanan, M.D., of Wise, an internist and Democrat, recently reelected to his second term. Senator Buchanan is highly respected by his colleagues in the Assembly; he is noted for his knowledge of the law and for his talent for clarifying and simplifying bills. A native Virginian, he is 65 years old.

The state of Florida has elected four physicians to its legislature; one is a senator and three are representatives. Their pictures are on the cover of a recent issue of the *Journal of the Florida Medical Association*, a splendid state journal received by a membership of over 10,000 doctors. Its editor is Gerold L. Schiebler, M.D. He editorializes on the physician-legislator as follows:

". . . we must encourage more physicians to seek public office, enter the legislative forum, and then make it possible for them to remain in the legislature long enough to garner legislative strength. Think of the effectiveness of our present four! Think also of the sad state of our legislative thrust if we had no physicians in the Florida legislature.

"Consider the position of our professional counterparts, the lawyers: 1) they have traditionally sought public office, so that 25-60% of each House may at any time be composed of lawyers; 2) their training is better designed to adapt to the legislative process; 3) laws promulgated by them will affect individuals who will be prosecuted or defended by them or their colleagues; 4) laws, when appealed, will be interpreted finally by lawyers sitting as judges on some court; and 5) the final governing body of the legal profession in Florida is the State Supreme Court —the members of which are all lawyers—with that body being a co-equal with the legislative and executive branch in State government.

"Should not the physicians be entitled to a parallel structure, with our State Board of Medical Examiners being tantamount to our Supreme Court on medical matters, or should we petition to have physicians placed on the Supreme Court itself?"

Bureau of Alcoholic Studies but permits establishment of local programs for the care of alcoholics.

Impaired Drivers

SB-150 (Truban)—*No Position. Carried over to 1977.* Relates to the reporting by physicians and others of disorders and disabilities that may affect a person's ability to operate a motor vehicle and provides for immunities from civil and criminal liability.

Nurse Midwives

HB-68 (Axselle)—*Supported. Enacted.* Provides for the control and management of nurse midwives to be transferred from the State Department of Health to the Joint Boards of Medicine and Nursing. Future midwives must be registered nurses, but present midwives are "grandmothered."

Hemophiliac Program

HB-108 (Diamonstein)—*Supported. Enacted.* Relates to the provision by the Board of Health of health services to persons suffering from hemophilia and related diseases.

Newborn Insurance

HB-128 (Elliott) — *Supported. Enacted.* Amends the newborn insurance bill enacted in



1975 to include coverage from the moment of birth in all insurance policies sold in the state and adds provision for this to include reissue or renewed policies, which was inadvertently left out of last year's bill.

Patient Hospital Records

HB-143 (Morrison)—*No Position. Enacted.* Provides that "upon proper request", copies of hospital records or papers shall be furnished at a reasonable charge to the patient or his attorney. Excludes mental records for review by patient.

Admission and Treatment of Mentally Ill Persons

HB-150 (Robrecht)—*No Position. Killed.*

HB-314—*Identical to HB-150. Killed.* Relates to involuntary detention, admission, and treatment of mentally ill persons, and increases the time of the temporary detention from 48 to 72 hours.

Mandatory Continuing Medical Education

HB-191 (Pendleton)—*Opposed. Carried over to 1977.* Relates to continuing medical education requirements for renewal of licenses and certificates to practice the healing arts; to become effective on and after July 1, 1978.

Posting of Prescription Drug Prices

HB-206 (Glasscock)—*No Position. Vetoed.* Relates to the advertisement of certain prescription drugs. Requires a list by generic name of common dosage of the fifty most commonly used drugs, as determined by the State Board of Pharmacy, specifying the price of the drugs and any other services incidental to dispensing drugs, such as fees for professional services, delivery service and the maintenance of medical profile records. Pharmacists may have had available for distribution the same price list in leaflet form for customers who requested it.

Prescription Drug Labelling

HB-207 (Glasscock)—*No Position. Killed.* Each prescription label would have had to show, in addition to usual contents, the strength of the drug, expiration date of the drug if appropriate, and the name of the original manufacturer of the drug.

Container Identification of Drug Manufacturer

HB-208 (Glasscock)—*No Position. Enacted.* Requires that packages of prescription drugs bear labels containing the name and place of business of the manufacturer of the final dosage form of the drug and, if different, the name and place of business of the packer and distributor.

Medication Profile Records

HB-209 (Glasscock)—*No Position. Killed.* Would have required the maintenance of medication profile records by pharmacists dispensing prescription drugs. The record would have included the name and address of the patient, and—if applicable—the family unit; year of birth or approximate age of the patient; drug sensitivities and chronic physical conditions if known by the patient; the date of dispensing the drug; assigned prescription number; name of dispenser; name, quantity and strength of the prescription drug. All records would have been maintained for three years from the date of the last dispensed prescription. The act would have become effective on January 1, 1977.

Handicapped—Realty Exempt

HJR-1 (Durrette)—*No Position. Carried over to 1977.* Provides real estate tax exemption for persons 65 years of age and over, or persons physically handicapped, or permanently or totally disabled.

Nursing Home Patient Bill of Rights

SB-207 (Holland)—*No Position. Killed.* Provided for a bill of rights and patient care policies for patients residing in nursing homes.

Child Abuse Investigative Record

HB-296 (Michie)—*No Position. Enacted.* Amended bill simply requires that those who report or complain concerning child abuse disclose information basic to the report, and requires that papers and records documenting child abuse be available for investigators. It remains to be seen whether this will permit access to information considered confidential, but such is unlikely.

Child Abuse Court-Ordered Examinations

HB-297 (Michie)—*No Position. Enacted.* This bill says that children whose abuse or neglect has been alleged may be ordered by the court to be examined.

Optometry School

SB-269 (Manns)—*Opposed. Enacted.* Relates to study for a regional school of optometry by the Council of Higher Education and asks for a $25,000 appropriation for the study.

Medical Scholarships

SB-346 (Walker)—*Supported. No action taken. Killed.* Provided for the establishment of ten medical scholarships for the Eastern Virginia Medical School.

48-Hour Involuntary Detention

SB-477 (Coleman)—*No Position. Killed.* "If the 48-hour period herein specified terminates on a Saturday, Sunday or legal holiday, that person may be detained as herein provided until the next day which is not a Saturday, Sunday or legal holiday."

Virginia Students in Virginia Medical Schools

SB-493 (Townsend)—*No Position. Carried over to 1977.* Provides for limiting the number of out-of-state students admitted to state-supported medical schools to ten percent of the total number of students admitted to such entering each year.

Autopsies

HB-364 (G. W. Jones)—*No Position. Killed.* "An autopsy shall be performed upon the death of any person whose death was an apparent result of a fire or who died when unattended by a physician or other known witness."

Certificate of Need

HB-596 (Teel)—*No Position. Killed.* Exempted from a Certificate of Need a nursing home project for which no public funds were to be expended, if such project would not increase the bed capacity of nursing homes in the area beyond 100 beds per 5,000 persons residing in such area.

Death With Dignity

HB-620 (Lechner)—*Opposed. Killed.* The Death with Dignity Act definitions, legalization of the "living will", duty of physicians, standard of medical treatment, immunity for physicians, revocation of the "living will", prohibitions and penalties.

Drug Advertising

HB-482 (McDiarmid)—*No Position. Killed.* Would have permitted the advertising of prescription drug prices in the media.

Anti-Kepone

HB-264 (McMurtrie)—*No Position. Carried over to 1977.* Relates to the registration of the manufacturing or distribution of toxic substances; penalties for violation.

NORTHERN VIRGINIA DOCTORS PROTEST

Activated by the Virginia General Assembly's failure to pass malpractice insurance legislation, Northern Virginia physicians have indicated they will form an emergency coordinating committee to find alternatives to escalating insurance costs and its increasing unavailability.

Dr. W. Leonard Weyl, Arlington, president-elect of The Medical Society of Virginia, said in a statement to the press: "Physicians in Northern Virginia believe it is our responsibility to our patients, our families, and ourselves to develop possible contingency programs when we can no longer get, or afford to buy, adequate professional liability coverage."

He said options might include shuttling emergency cases to nearby states, scheduling elective surgery out of state, and refusing to perform complicated surgical procedures and to care for "high risk" patients.

Sexual Sterilization

HB-726 (Stambaugh)—*No Position. Enacted.* This was introduced for the purpose of permitting 18-year-olds to obtain voluntary sterilization, but the thrust of the bill was reversed, in that the age of 21 was retained and the court is now permitted to authorize sterilization if the health of a minor would be endangered by a pregnancy.

Mandatory Mental Illness Coverage

HB-724 (Stambaugh)—*No Position. Enacted.* This bill requires accident and sickness policies to cover inpatient hospitalization for mental, emotional, or nervous disorders similar to that provided for other illnesses, except that a 30-day limit may be imposed.

Family Planning Information for New Parents

HB-757 (Hailey)—*No Position. Carried over to 1977.* The Bureau of Vital Records and Health Statistics shall, upon receiving notification of every birth occurring in Virginia, mail to the parents family planning information and a list of family planning clinics in the Commonwealth, furnished by the State Department of Health.

Separate Chiropractic Board

HB-821 (Axselle)—*Opposed. Carried over to 1977.* Provides for the establishment of a separate chiropractic board and removes chiropractors from the control of the State Board of Medicine.

Interpreters for Deaf Persons

HB-830 (Wilson)—*No Position. Vetoed.* Provides for interpreters for deaf persons who are subject to involuntary commitments and who are alleged to be mentally ill.

General Anesthetics by Podiatrists

HB-869 (Pendleton)—*Opposed. Carried over to 1977.* Strikes out the clause, "nor the use of other local anesthetics," allowing podiatrists to operate using general anesthetics.

Rights of the Unborn

HJR-43 (Durrette)—*No Position. Killed.* Memorialized Congress to amend the United States Constitution to protect the rights of the unborn.

Medical Malpractice Premium Equalization Act

HB-884 (Marks)—*No Position. Carried over to 1977.* This bill incorporates Commissioner Day's plan for broadening the medical malpractice distribution base to the hospitals of Virginia.

Wound Reporting

HB-1095 (Hobson)—*No Position. Enacted.* Section 54-276.10 has now been broadened so that a report is required of any doctor who has reason to believe the wound for which he has treated any patient was not self-inflicted.

Chiropractic Acupuncture

HB-1117 (Cranwell)—*Opposed. Killed, Senate floor.* Provided for any regulation promulgated by the Board of Medicine to be construed so as to prohibit persons authorized to practice chiropractic from using acupuncture.

Commission of Health Regulatory Boards

HB-1206 (McMurtrie)—*Opposed. Carried over to 1977.* Provides for the establishment of Commission of Health Regulatory Boards, including Board of Medicine, Board of Dental Examiners, Board of Nursing, Board of Optometry, Board of Pharmacy, and Board of Embalmers and Funeral Directors. The Board of Medicine opposes this bill.

Toxic Substance Information Act

HB-1273 (Glasscock)—*No Position. Killed.* The purpose of this act was to collect, catalog, and evaluate all information concerning substances which are toxic or which are potentially toxic in certain concentrations, and under certain conditions to provide for use in the discharge of their respective regulatory functions, and thereby protect the public safety and welfare of the citizens of the Commonwealth.

Physician Toxic Substance Diagnosis Reporting

HB-1277 (Glasscock)—*No Position. Killed.* Required every physician to report any suspected or diagnosed disease caused by exposure to any toxic substance, or any person who is suffering from any infectuous, contagious, communicable, and dangerous disease as designated by the State Board of Health on blanks furnished by the Board or local health department.

Willard C. Osburn
Director, Legislative Activities

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Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
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1155 Fifteenth Street, N.W.
Washington, D. C. 20005

Flu Sunday for the Elderly

JOHN ALEXANDER, M.D.
Lovingston, Virginia

The recent appearance of swine influenza virus, thought to be similar to the cause of the disastrous epidemic of 1918-19, has prompted plans for a national immunization effort. The following article raises an important question about the possible success of such a program, especially since there is no conclusive evidence that swine flu actually will cause a significant problem. Also, because of the need for mass production of vaccine, purification methods may be less than optimal, and the resulting large number of adverse reactions could significantly affect participation..

INFLUENZA is a serious disease for those over 60 years of age and anyone with a chronic disease. For many years, the Center for Disease Control has recommended that people in the high risk groups be immunized. The best estimate is that 10-20% of the high risk population receive influenza protection each year.

The Thomas Jefferson District Health Department, Albemarle County Medical Society, and the Jefferson Area Board for Aging recently joined together to try to increase the protection of elderly residents in the area. On a Sunday afternoon in October, 1975, flu shots were administered to 1,146 persons, all of them past middle age and living in Charlottesville and the surrounding counties. Over 200 volunteers and numerous organizations participated.

Areas served by the immunization locations were Albemarle, Fluvanna, Louisa, Nelson, and Greene Counties, and Charlottesville. Participation was much the same in each of these areas, the average being 7% of the 60-years-and-over population.

Publicity was begun about three weeks before and consisted of TV and radio announcements, newspaper articles, leaflets in shopping bags, and church announcements. When participants were asked their source of information about the program, 74% said they had read about it in the newspaper. The next best source was a friend, which accounted for about 10%.

Transportation was made available in all areas but was used by only a dozen people. There was a charge of one dollar for each vaccination.

Participants were asked about previous influenza immunizations, and only 37% had been immunized during the previous year, suggesting that at least two-thirds of those immunized would not have received influenza protection without the program.

Results

A sample was selected to determine adverse reactions to the flu vaccine (Bivalent Influenza Vaccine, Merrell 75-76, Lot #1157 EK). From the list of 1,146 persons immunized, 117 names were selected at random, and followup information was obtained by phone, mail, or home visit on 115 of these.

Systemic reactions did not seem particularly common or severe, as can be seen in Table I.

Table I

Systemic Reactions

	None	Mild	Moderate	Severe
Headache	85%	7.8%	2.6%	4.3%
Chills	93%	2.6%	1.7%	2.6%
Muscle Ache	90%	5.2%	4.3%	0
Weakness	93%	4.3%	2.6%	0
Nausea	98%	1.7%	0	0

Fever was noted by 6% of the patients, but only one had a temperature above 101°F.

Redness was the most common local reaction, and only one patient described severe

From the Nelson County Health Department, Lovingston.

Submitted 2-26-76.

pain. The local reaction rates are shown in Table II.

Reaction rates were also analyzed by age. Generally, as age increased the percentage of

Table II

Local Reactions

	None	Mild	Moderate	Severe
Pain	87%	8.7%	3.5%	.87%
Redness	84%	12.2%	2.6%	.87%
Swelling	90%	7.8%	1.7%	0

persons with reactions decreased. For example, only 46% of those aged 60 to 64 described no reaction, compared with 75% in the age group 80 and over. The progressive

Table III

Reactions by Age

Age	Number	Only Local Reaction	Systemic Reaction
60	7	1	1
60-64	28	7	8
65-69	34	7	6
70-79	29	1	8
80 & Over	16	1	3
Total	114	17 (15%)	26 (23%

decrease of reaction rate by age was, however, not statistically significant when the chi-square test was employed. Table III shows the reaction rates by age.

The majority of the reactions lasted between 12 and 24 hours. Three persons noticed weakness and muscle aches lasting over 48 hours. No significant differences in reactions could be found when sex and racial characteristics were analyzed.

Conclusion

A great deal of effort produced a relatively small result: 7% of the elderly population in the Charlottesville area were protected against influenza. About one-third of these had been immunized in the previous year and would likely have received the vaccine from another source.

It is our estimate that in a campaign of this type, utilizing existing community resources, no more than 15% of the elderly population will participate. This may be due to fear of injection, a belief that the vaccine is worse than the disease, or lack of motivation to protect one's health. Considering the variability of the virus, marked difference in yearly prevalence, the need for yearly booster, and such poor participation, mass influenza campaigns would not seem to produce significant benefits. A yearly informational campaign and perhaps a few community centers offering low cost vaccine might well be sufficient, considering other priorities.

For reprints: Doctor Alexander
Nelson County Health Department
Lovingston VA 22949

Illustration by Denis Orloff



A resource for therapies, including a school for emotionally disturbed children

The Human Resource Institute of Norfolk offers individualized treatment programs within a therapeutic community to all ages and diagnostic categories of mentally and emotionally disturbed adults, adolescents, and children. By utilizing various individual and group therapies the patient becomes aware of his own feelings and his relationship to others. The diversified therapies increase the individual's self-esteem and encourage him to function in an effective manner.

An intensive program of community activities offered through the Rehabilitative Services Department promotes interpersonal relationships among patients and staff, and stimulates the patient's creative potential. Activities such as dance therapy, recreational therapy, occupational therapy, psychodrama, and music therapy, are individualized according to the patient's needs.

An integral part of treatment for the emotionally disturbed adolescent or child is the continuance of his education in a therapeutically controlled environment. HUMAN RESOURCE ACADEMY, a fully licensed and certified school, promotes learning with teachers specially trained in teaching the emotionally disturbed and learning disabled students.

Pharmaceutical therapy and close association with consultant physicians of all specialities are important aspects of patient care at Human Resource Institute.

To find out more about our comprehensive program contact the Co-Medical Directors, Dietrich W. Heyder, M.D., F.A.P.A., or Fathy A. Abdou, M.D., F.A.P.A., Human Resource Institute of Norfolk, Human Resources Building, 100 Kingsley Lane, Norfolk, Virginia 23505. Phone (804) 489-1072.

Case Reports . . . .

Giant Folliculitis Keloidalis

Kenneth E. Greer, M.D., and
Louis E. Harman, M.D.
Charlottesville, Virginia

Folliculitis keloidalis, also known as acne keloidalis, is a chronic inflammatory process of the hair follicles on the posterior neck of young men. The majority of reported cases have occurred in blacks. The end result of the inflammatory process is scar formation, which may at times be extensive and cosmetically disfiguring. Although mentioned in most major textbooks of dermatology, the disorder has been infrequently reported in the more recent literature. A case of giant folliculitis keloidalis in a white man with Down's syndrome stimulated this report and a review of the literature.

Case Report

A markedly obese 26-year-old white man with Down's syndrome was referred to the dermatology department of the University of Virginia in January, 1975, for evaluation of an inflammatory process on the nape, which had become progressively worse over a six-year period. The family was concerned that the large mass which had developed in the area might be malignant, although there had been no recent significant change in the lesion.

The process had begun at the hairline on the posterior neck when the patient was 18 years of age. He was treated on numerous occasions by several physicians for "ingrown hairs" with topical and systemic antibiotics, mechanical depilation, depilatory creams, frequent cleansing of the area, and allowing the hair to grow long, but the disorder showed no improvement with any therapeutic regimen. Deep abscesses had been treated by incision and drainage on several occasions. Initially the lesions had been scattered on the nape, but in the previous three years they had coalesced to produce a large confluent mass which discharged foul smelling exudate from multiple foci.

The patient never complained about the process, and he did not appear to manipulate the area. He could not talk or read, but he was fully ambulatory and could dress and cleanse himself. The family stated that his chief pastime was eating, which he apparently did much of the time. He had never had significant acne vulgaris, furunculosis, or medical problems other than Down's syndrome. Other than incision and drainage of deep abscesses on his neck, the patient had had no previous surgical procedures, and lacerations and other wounds had healed normally without excessive scar formation. There was no family history of severe acne or a similar inflammatory scarring process involving the posterior neck.



Fig. 1. Giant folliculitis keloidalis of the nape.

Physical examination revealed a short (150 cm), markedly obese (102 kg) white man with features typical of Down's syndrome. The skin appeared normal except for the area on the posterior neck, mild keratosis pilaris of the back and extensor extremities, and marked striae of the axillary area. Specifically, there was no evidence of active acne vulgaris or acne scarring, pseudofolliculitis barbae, other hypertrophic scars or keloids, or lesions elsewhere in his scalp. The nape was covered by a huge keloidal plaque with areas of abscess and sinus tract formation (Fig.

Submitted 8-12-75.



Fig. 2. Replacement of normal epidermal appendages by hypertrophic connective tissue and an inflammatory infiltrate (H & E x 17).

1). Purulent exudate could be easily expressed by applying pressure adjacent to the few tufts of broken hairs on the surface of the plaque. The mass, which measured 15 x 10 cm, was firm, and there were boggy or soft areas scattered throughout it. There were no comedones adjacent to or on the surface of the sharply demarcated tumor.

Culture of the exudate revealed a few coagulase positive Staphylococcus aureus organisms which were sensitive to penicillin and tetracycline.

A biopsy specimen from the plaque showed extensive thickening of the dermis with marked inflammation, keloidal cicatrization, focal areas of foreign body reaction, and complete absence of intact epidermal appendages (Fig. 2). The collagen bundles were thickened and arranged haphazardly. The inflammatory infiltrate consisted primarily of plasma cells, lymphocytes, and histiocytes. There were fragments of broken hairs in the areas of foreign body reaction in addition to the multinucleated giant cells (Fig. 3).

It was felt that the only treatment which might be curative for this chronic process would be wide surgical excision and grafting of the area. However, since the lesion was asymptomatic and of no concern to the patient, a decision was

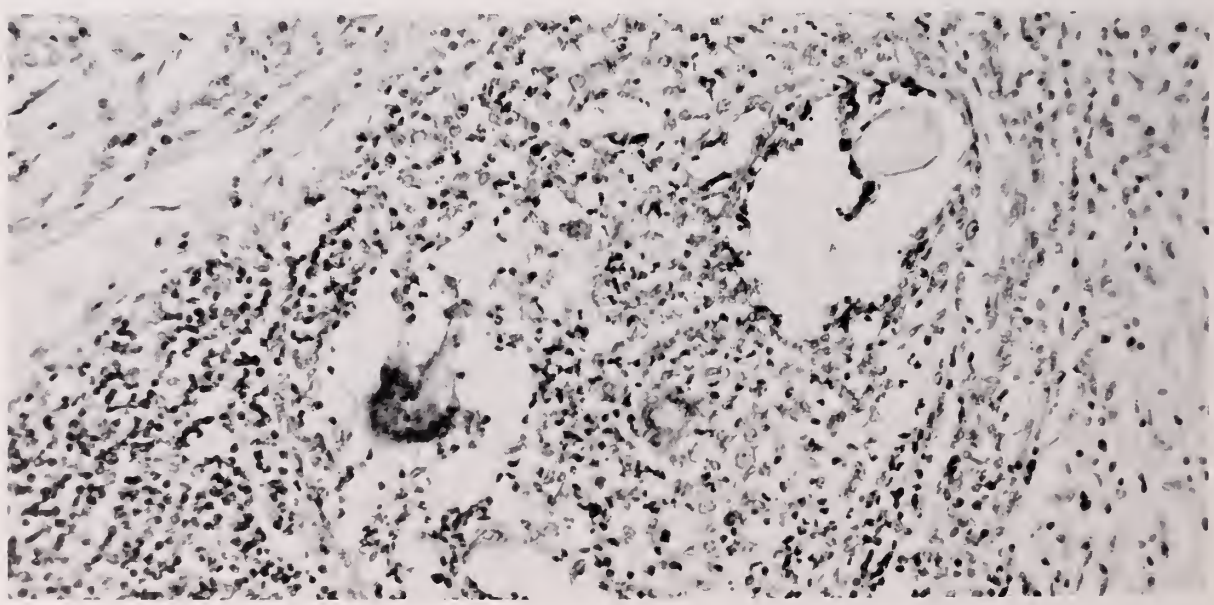


Fig. 3. Multinucleated giant cells, fragment of broken hair, and marked inflammatory infiltrate. (H & E x 240).

made to treat him conservatively with warm moist compresses, cleansing, and oral antibiotics. The family's major concern was whether or not the process had become malignant; they were not particularly concerned with the cosmetically disfiguring appearance of the area. The family seemed reassured when they were informed that the lesion was not malignant and that the process might possibly show some improvement in time, either spontaneously or with conservative dermatologic therapy.

Comment

Folliculitis keloidalis probably represents an inflammatory and scarring process secondary to ingrown hairs, analogous to pseudofolliculitis barbae, but often on a much more extensive scale. Both disorders are seen primarily in black men, and both may be related to the sharp end on "curved" hair produced either by shaving the beard or cutting the hair short on the posterior neck. Certainly discontinuation of shaving is therapeutic for pseudofolliculitis barbae, although allowing the hair to grow long on the neck may not be beneficial in folliculitis keloidalis.

Folliculitis keloidalis was described over a century ago as dermatitis papillaris capillitii, later as acne keloidalis, and, finally, Fox suggested the name folliculitis keloidalis as a better term for this distinct clinical entity.[1] Folliculitis keloidalis is the term under which the disorder is listed in the Cumulative Medical Index and should probably be the accepted name for the ailment, although a recent and very informative report in the plastic surgery literature still refers to the disorder as acne keloidalis.[2] Certainly the process is related more to folliculitis and perifolliculitis of terminal hairs than to obstruction of pilosebaceous units characteristic of acne vulgaris. Some might argue that the word keloidalis is also inappropriate and that hypertrophic scar would be technically more correct. Others feel that the only significant difference between keloids and hypertrophic scars is quantitative.[3]

Although the exact etiology of folliculitis keloidalis is unknown, the pathogenesis has been fairly well outlined. Histologically, the process begins as a folliculitis and perifolliculitis with the neutrophil being the predominant infiltrating inflammatory cell. Clinically, the early manifestations include scattered papules and nodules from which purulent exudate may be expressed. Bacterial organisms may or may not be cultured from the exudate, but they are considered by most observers to be secondary invaders and not the primary cause of the inflammation. Not uncommonly, areas of foreign body reaction in the dermis contain bits of hair and follicle debris, as well as multinucleated giant cells. As the disorder becomes more chronic, the keloidal scarring becomes evident clinically and histopathologically. The inflammatory infiltrate at this stage consists primarily of plasma cells, lymphocytes, and histiocytes. The dermis is considerably thickened, and the epidermal appendages are replaced by bundles of hypertrophic sclerotic connective tissue, between which are seen the foci of inflammatory cells.[4] Clinically, the papules and nodules coalesce to produce the thickened scar in the posterior neck with alopecia, pustules, and, occasionally, discharging sinuses. Although frequently asymptomatic, folliculitis keloidalis may be associated with significant pain and pressure from deep abscesses, bothersome discharge of foul smelling exudate, and concern over the appearance of the cosmetically disfiguring mass or masses.

Various theories have been suggested as to why the process develops in the precise location at the posterior hairline, including irritation from shirt collars or creasing of the skin of the neck, infection, irritation from short-cut hair in this region, or chronic irritation from self-manipulation. This latter point might possibly help explain the development or perpetuation of the process in this patient with Down's syndrome, but the family specifically denied that the patient manipulated his nape. No one theory for the cause of this disorder has been generally accepted or proven, and, as stated earlier, the specific etiology of folliculitis keloidalis remains an enigma. The development of such a large lesion of the disorder in a caucasian patient is certainly extremely unusual, although even more extensive cases in blacks have been reported previously.

Accepted treatment of folliculitis keloidalis

includes conservative dermatologic or surgical therapy. Treatment in the early stages may consist of moist compresses and cleansing, local or systemic antibiotics, injections of corticosteroids into the nodules, incision of deep abscesses, and manual depilation. Depilation by x-ray is no longer considered conservative dermatologic treatment, and this form of therapy should probably be avoided completely. Treatment in the late keloidal stage is probably done best by wide local excision of the process with primary closure or skin grafting. There is some evidence to suggest that such keloidal processes are not only chronic, but that they may also be self-limiting.[3] If the lesion is asymptomatic and the patient is not concerned with the disfiguring appearance of the area, folliculitis keloidalis can probably be left alone and may resolve spontaneously.

In summary, folliculitis keloidalis is a distinct entity of the posterior neck that includes a wide clinical spectrum from small keloidal papules and pustules to giant plaques or tumors. The incidence, etiology, and eventual prognosis have not been adequately studied, but the pathogenesis has been fairly clearly described. It seems to be definitely associated with a folliculitis followed by keloidal cicatrization and has no definite relationship to acne conglobata, hidradenitis suppurativa, or dissecting cellulitis of the scalp (the so-called follicle occlusion triad). Treatment early in the course of the disease may be conservative, as one cannot predict just how severe a process any one individual will have. The treatment in severe cases, especially if the folliculitis keloidalis is symptomatic or bothersome cosmetically, is surgical excision of the entire affected area.

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600091

Brain Tumor: A Difficult Diagnosis

A. R. Coppola, M.D.
Newport News, Virginia

"He who cares for patients suffering from brain tumors must bring to his problem much thought and stout action. There is need also of a formidable optimism for the dice of the gods are loaded!" —*Foster Kennedy*[1]

The textbook diagnosis of headache, nausea, and vomiting, accompanied by papilledema, would seem to render the diagnosis of probable brain tumor simple enough. Unfortunately, while this may be true in many instances, chance discovery of a brain tumor may occur with few if any of the above symptoms and signs. It is with this thought in mind that the following cases are presented to alert the practicing physician to consider this possible diagnosis even when there is a paucity of symptoms and neurologic findings.

Case 1

A 32-year-old white female diagnosed as catatonic schizophrenic on the psychiatric service became gradually less responsive after electric shock treatment. The neurologic resident performed a spinal puncture which revealed greatly increased spinal fluid pressure, and the patient became comatose. Neurosurgical consultation was obtained and on ventriculography a most bizarre study was obtained, with shift suggesting tumor. Craniotomy revealed melanosarcoma involving meninges and cerebral substance. Subsequent history revealed removal of melanoma some years previously in a dermatologist's office.

Case 2

A 50-year-old white female with combined anxiety and depressive symptoms failed to improve under psychiatric treatment and developed increasing drowsiness progressing to stupor and eventual coma. Transfer for neurosurgical evaluation revealed a comatose patient who, at craniotomy, was found to have a frontotemporal astrocytoma Grade III. She survived an additional year after surgery and radiation therapy.

Case 3

A 35-year-old white male engineer was admitted with a history of transportation to the hospital after awakening in a veterinarian hospital. According to fellow workers he had left the job and driven his car a distance of approximately 20 miles. When they came upon him, he had pulled off the road and was unconscious. He had apparently experienced a seizure and because of this he was taken to a veterinarian hospital—the nearest stop! After admission to the general hospital, further history revealed that about one year prior to this he had emerged from a deep mine shaft which he had inspected and had experienced a generalized seizure followed by loss of consciousness. He had felt perfectly well in the interim. Both EEG and radioactive brain scan were abnormal, as was arteriography demonstrating a right temporo-parietal space lesion. At operation he was found to have a right temporo-parietal astrocytoma Grade III. There was at no time headache, nausea, vomiting, or papilledema, and the neurologic examination revealed no abnormality.

Case 4

A 51-year-old white male shipyard worker was seen because of persistent headache of three weeks duration. He stated that he had been the victim of headaches of a "migraine" character for many years, but this recent headache, while similar to those in the past, had failed to disappear, and he had been unable to work. Neurologic examination failed to reveal any abnormality. After admission to the hospital, EEG, brain scan, and arteriography were pathognomic of brain tumor, and surgery revealed an astrocytoma Grade III of the right frontal lobe.

Discussion

Neoplasm of cerebral tissue, whether primary or metastatic, may not infrequently occur in the absence of the classic textbook criteria. A single seizure, personality change, unexplained headache, syncopal episode, transient and fleeting neurologic symptoms may herald the onset or presence of a brain tumor. Once suspicion of a neoplasm is entertained, the patient should be subjected to roentgenologic studies, EEG, brain scan, arteriography, and air studies if necessary. With this thought in mind perhaps more cerebral tumors amenable to successful surgery may be delineated in the future.

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1. Bailey P: Intracranial Tumors (2nd Edition). Springfield, Illinois, Charles C. Thomas, 1948, p 478

Submitted 7-16-75

338 Main Street
Newport News, Virginia 23601

Medicare Readies Some Unexpected $$Checks$$

Some doctors may soon be receiving compensation for underpayment from Medicare, according to Curtis J. Kelly, associate manager of Travelers-Medicare in Richmond. The reason for the adjustments is a bit complicated, but here's a go at an explanation.

When fiscal year 1976 prevailing charge screens were implemented in August of 1975, the application of the economic index may have reduced the prevailing charge levels below the dollar amount paid during fiscal year 1975. (Mr. Kelly refers the reader to his column in the September, 1975, issue of the *Virginia Medical Monthly*.)

But along came Public Law 94-182, enacted last December, which says this discrepancy isn't fair. (What a commendable decree!) And the Law instructs Medicare carriers to (1) adjust prevailing charge screens to eliminate such reductions, and (2) to recompense Medicare payees if they received less than the amount payable on the basis of the adjusted prevailing charge screen. If, the Law adds, picking at nits, the amount involved is at least $1.00 for 100% reimbursable services and $1.25 for all others.

Mr. Kelly has instructed his office to implement the Law as rapidly as possible. *Splendid.*

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Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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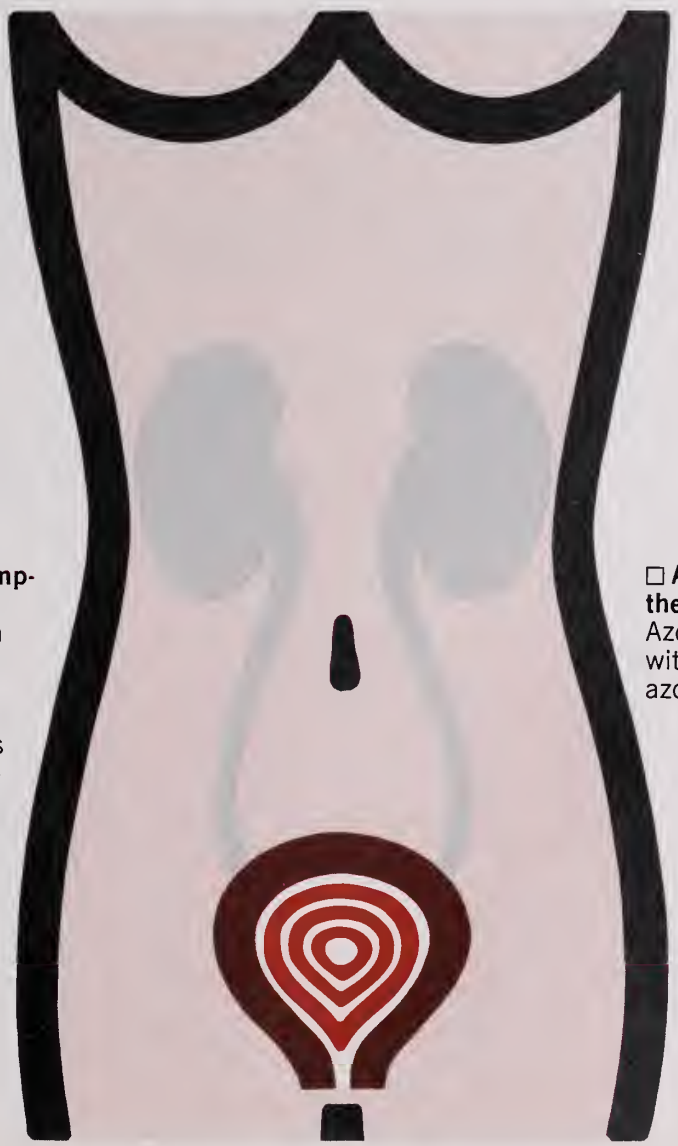
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* **Warning**
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***Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly** impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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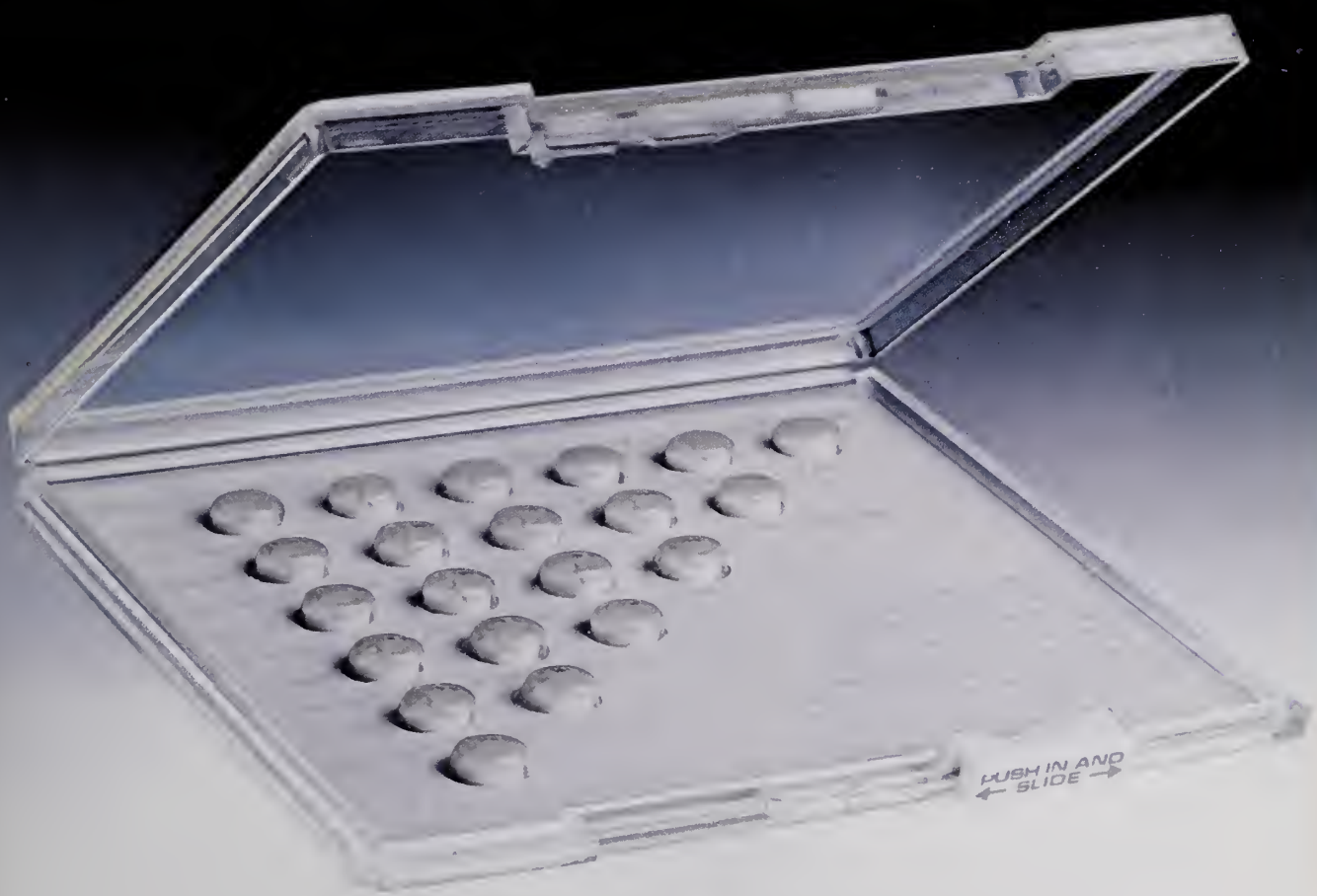
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Final classification of the less than effective indications requires further investigation.

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy. See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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Cancer Trends . . . .

Carcinoma of the Colon: Present Status and New Developments

FRANCIS E. ROSATO, M.D.
JOHN LANGLEY, M.D.
Norfolk, Virginia

CARCINOMA of the colon remains a major disease. Currently, there are 75,000 new cases and 45,000 deaths being reported annually from this disease alone. The crude mortality rate is 60%. It remains prevalent in the Northeast region, in urban populations, and in those areas of higher socioeconomic standing.

Interesting studies on the etiology of colonic carcinoma center around the observation by Burkitt[1] that the disease is rare in Africa, where diets high in bulk and low in refined sugars produce large stools and a regular evacuation pattern. The theory has been advanced that carcinoma may arise from prolonged contact of stool carcinogens with colonic mucosa in diets which are low in bulk and high in refined sugars.

Polyps and Cancer

There is a definite correlation between certain polyp forming diseases and carcinoma of the colon, most notably familial polyposis. This condition is inherited as a Mendelian dominant trait with variable penetrance. Approximately 40% of offspring are affected, with equal distribution between male and female. The resultant diffuse colonic polyposis inevitably leads to carcinoma in 50% of these individuals by age 30 and 100% by age 50 years. Aggressive surgical prophylaxis is the accepted treatment; however, controversy exists over the management of the rectal segment which usually is involved with polyps.

From the Department of Surgery, Eastern Virginia Medical School, Norfolk.

Lockhart-Mummery[4] reported a favorable experience in a large series of patients with familial polyposis treated by subtotal colectomy with ileoproctostomy. Since spontaneous regression of remaining rectal polyps frequently occurs, he felt that this was a safe procedure where patients could be followed by frequent proctoscopy and new lesions could be fulgurated. Moertel,[5] in a series from the Mayo Clinic, felt that there developed an unacceptably high incidence of carcinoma in the retained rectal segment and recommends total colectomy as the initial procedure of choice.

Villous adenoma, named for its characteristic frond-like appearance, generally arises in the rectum as a large, bulky, multilobulated polyp. Invasive cancer is found in about one-third of cases in most series. The large size of these lesions makes "spot biopsy" unreliable in ruling out carcinoma. Total excision of the polyp with multiple pathological sectioning is required to rule out invasive cancer.

Adenomatous polyps are probably the commonest variant of polyps associated with carcinoma, although their malignant potential is questionable. Cancer may be found in such polyps and is clearly related to size. Polyps less than 1.0 cm in size have about a 1% chance of being malignant, and may be safely followed. Those between 1.0 and 2.0 cm also may be followed, provided there is no family history of carcinoma and stools remain negative for occult blood. A repeat barium enema should be done in six months; polyps which double in size may harbor cancer and should be resected. All polyps greater than 2.0 cm

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should undergo excision by whatever means are required. Simple excision is considered definitive therapy if malignant cells are confined to the tip and the stalk is tumor-free. The presence of cancer in the base of an adenomatous polyp or in a sessile polyp requires formal bowel resection.

The risk of cancer developing in patients with ulcerative colitis increases 10% per decade for those patients having the disease more than ten years. This risk is increased when the disease begins in adolescence, or when it involves the entire length of the colon. Despite these considerations, there is less than general agreement that colectomy should be performed prophylactically to protect against colon cancer—even though the 20% survival rate for carcinoma arising in ulcerative colitis is much poorer than more common forms of colon carcinoma. The development and refinement of histologic criteria, such as described by Morson,[6] may allow for identification of higher risk groups who should logically undergo colon resection prophylactically.

Pathological Aspects

Approximately 70% of tumors are still found within reach of the sigmoidoscope and the remainder fairly evenly distributed in the descending, transverse and ascending colon. At the time of surgery, approximately 50% of patients already have evidence of nodal involvement. The most important factors in predicting survival data remain nodal status, depth of penetration (Dukes' classification) and evidence of vascular invasion. The liver, lung, bone, and brain, in that order, are common sites of involvement when metastases do appear. At the time of diagnosis an unresected tumor carries an approximate survival time of ten months.

Signs and Symptoms

The characteristic pattern of right-sided colonic lesions is anemia, weakness and weight loss, while on the left side obstruction, melena, and pain are common. However, one must appreciate that obstructing lesions are now almost as common on the right side as on the left side. A mass is palpable in about 70% of right-sided lesions and about 30% of left-sided lesions at some time in the course of the disease. There seems to be no association between cancer of the colon and hernias. This fact is borne out by multiple series in which barium enemas were done prior to hernia repair in patients over 50 years of age.

Two important new diagnostic tools may aid in early cancer detection. The first is an acceptable guaiac impregnated filter paper slide, which makes routine testing for occult blood possible in the general population. This technique, the "hemoccult" system is acceptable to patients, and may be applicable as a case finding tool. While proctosigmoidoscopy has been the cornerstone of diagnosis of colon disease, the addition of the second new tool, colonoscopy, is likely to enhance cancer detection in this area. Wolff and Shinya,[10] for example, reported performing 303 polypectomies in 218 patients using the colonscope; 46 of these polyps had either atypia, carcinoma in situ, superficial carcinoma, or invasive carcinoma. The incidence of complications was low and the obvious advantage of this technique immediately apparent.

Most roentgenologists prefer routine barium enema examination to double contrast radiography for the diagnosis of intestinal lesions, reserving the latter for situations where routine examination was not definitive. This technique is effective more than 90% of the time in detecting lesions which are present.

Carcinoembryonic Antigen

Carcinoembryonic antigen, a neo-antigen presumably produced by derepressed tumor cells, was thought specific for adenocarcinoma of the colon when first described. Subsequent studies have shown it present in cancer of the pancreas, breast, stomach, and ovary, as well as in certain inflammatory diseases, such as ulcerative colitis, granulomatous colitis, cirrhosis, and pancreatitis. It is known to be elevated in 40% of patients whose disease is confined to the mucosa and in almost 100% of patients with transmural extension and distant metastases.

The carcinoembryonic antigen, therefore, may have preoperative value as a prognostic tool. In one study, patients with carcinoembryonic antigen values of less than 2.5 nanograms per milliliter had a 5% recurrent rate over a two-year period, while those with a carcinoembryonic antigen of 7 nanograms or more showed a 75% recurrence rate in the same period of time. Postoperatively, it is of value in documenting total tumor removal, since it should revert to normal when all tumor has been excised. It is likewise useful in monitoring response of patients to chemotherapy or radiotherapy, or for following patients post-surgically, since recurrence and regrowth of tumor are usually preceded by an elevation of the carcinoembryonic antigen level.

Therapy

The only curative treatment for cancer of the colon is radical surgical excision as soon as possible after the diagnosis is established. Tumors of the right colon are treated by standard right hemicolectomy, including ligation of the right branch of the middle colic artery. Those of the left colon are treated by left hemicolectomy. Transverse colon lesions require resection including both flexures with colo-colostomy. Tumors in the sigmoid and rectum, to within 8.0 to 10.0 cm of the anal verge, can be treated by anterior resection, while lesions below that level require a combined abdominoperineal proctosigmoidectomy. Barnes[1] and Cole[3] first suggested that early lymphovascular ligation combined with occluding tapes above and below the tumor were valuable initial steps in controlling intra-operative dissemination of tumor. They further recommended that the resection proceed from the mesenteric root laterally, so that division of the lateral peritoneal reflection (line of Toldt) would be the last portion of the procedure. Capitalizing on these recommendations, Turnbull[8] acquired a large personal experience showing a decidedly improved five- and ten-year survival rate in the "no touch" group, when compared to a matched group of patients treated by conventional techniques. Furthermore, these improved figures seemed to apply particularly to patients in the Dukes-C classification. This technique is valuable in right and left sided lesions, but is technically impossible to perform in low-lying lesions.

Madden has repopularized the electrocoagulation technique proposed by Strauss[7] and uses it as a definitive procedure in the following categories: 1) tumors which involve less than one-third the lumen circumference and which are within 10.0 cm of the anal verge, 2) patients too ill to withstand proctosigmoidectomy, and 3) patients who refuse proctosigmoidectomy. Approximately three separate sessions are required to locally control the tumor with electrocoagulation. The results in this group, however, are comparable to those treated surgically. An on-going prospective study is now underway to evaluate this as definitive therapy; it remains an acceptable alternative in the patient categories outlined above.

The use of preoperative radiation therapy prior to proctosigmoidectomy has had some promising initial results; prospective randomized studies under the direction of radiotherapists are on-going to test the hypothesis that such therapy may be a worthy adjuvant preoperative measure. For locally unresectable lesions, Williams[9] has reported effective use of a course of 6,000 rads to control bleeding and relieve mucorrhea and tenesmus.

Fluorouracil is the best single chemotherapeutic agent currently available for unresectable cancer. It is variably effective in controlling symptoms and generally has no effect on median survival time. It has been proved ineffective as an adjuvant agent in several studies, although some promising results have been forthcoming when combined with nitroso urea compounds.

Although several immunotherapy programs are on-going, including the use of BCG, enzyme altered cells, and virally altered cells, results are too preliminary to comment upon at this time.

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COMMENT

We welcome Dr. Rosato as a co-editor of "Cancer Trends". Dr. Rosato came to Virginia in 1975 to become the Chairman of the Department of Surgery at Eastern Virginia Medical School in Norfolk, having had a major interest in clinical cancer problems during his distinguished career on the faculty at the University of Pennsylvania. We believe Dr. Rosato's expertise in the field of oncology and his interest in continuing education will be a superb resource to us in the future activities of this column, which is sponsored by the Professional Education Committee of the Virginia Division, American Cancer Society. It is with great pleasure that we welcome him as our co-editor in this venture.

In the foregoing article, the authors have summarized the status of carcinoma of the colon and have certainly touched most of the bases. We would agree that early detection is still a major motive for all of us if we are to achieve optimal results since the stage of the disease is so directly related to prognosis. It is also clear that carcinoembryonic antigen is not a means for early detection as they point out, since the yield is so low for early lesions. Alertness to possible symptoms, the frequent use of digital rectal examination and sigmoidoscopy as part of routine physical examination, and the liberal use of tests for occult blood in the stool are still basic approaches of great value.

From the standpoint of treatment, they have not stressed an adjuvant approach to our standard surgical resection and we believe it is wise to maintain this position. The role of preoperative radiation therapy for low-lying lesions in the rectum is still under study due to conflicting results that have been obtained in randomized clinical trials. It is our impression that this should not be recommended as a routine procedure until more conclusive data can be obtained. We have had a major interest in adjuvant chemotherapy for patients undergoing curative resection for colon and rectal carcinoma and have recently reported a clinical trial using 5 FU both intraoperatively and postoperatively for a period of one year.[1] This combined study from the Medical College of Virginia and the University of Virginia failed to show benefit from the adjuvant use of this single chemotherapeutic agent utilized in a prolonged fashion. Certainly this does not mean that further research is not indicated in this area as we feel that some regime of adjuvant chemotherapy will be our future hope for improving results currently obtained by standard resectional procedures. It is conceivable that some drug combination as an adjuvant to surgical resection may improve results but the routine utilization of adjuvant chemotherapy should await the demonstration of benefit by current or future prospective clinical trials. The same comment is undoubtedly relevant to the potential of adjuvant immunotherapy, an area in which Dr. Rosato has had extensive investigative experience.

Again, a hearty welcome to our new co-editor!

Walter Lawrence, Jr., M.D.
J. Shelton Horsley, III, M.D.

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Epidemiologic Observations of Virginia Suicides, Part II

George Moore, M.D.
John Buckman, M.D.
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THIS study of 89 suicides based solely on death certificate data tends to dispel certain myths surrounding suicides and points to a conclusive approach toward solving the problem. The etiology[3] of suicides, like that of schizophrenia, covers a multitude of divergent causes. Suicide may be the end result of a process, not the process itself. In most behavioral disorders, we have at least part of the process at hand for study. In suicides, all we have is the end result, arrived at by a variety of paths. Unravelling the causes after the fact can best be done through retrospective research beginning with the act of suicide itself. The fact[3,4] that suicide prevention centers do not tend to prevent suicide is proof enough of this theory.

The high suicide rate in the Albemarle County area may be accounted for by the relatively high number of whites in the population. Over 94% of our suicides occurred among whites, yet the population base of whites was 86%. The presence of the University of Virginia in the area, in spite of a high enrollment of young white males, does not seem to be a significant factor, as shown by the higher suicide rates both in the Winchester and Eastern Shore areas of Virginia. From our data, only one university student suicide was recorded annually. We do not know the number of university students, if any, who committed suicide during their vacations away from Charlottesville.

Rates of suicide were highest among white males. That no black female committed suicide over a period of five years is significant. White male and female suicide rates demonstrated age-specific peaks; these varied according to sex. Peak suicide years for white males were ages 15-24, 45-54, and 65-plus years. The suicide peak for white females occurred between 25 and 54 years of age. These configurations may not be difficult to understand. All people are motivated to search for the "good life". According to our stereotypes for males, most of life's satisfactions are derived from identity with work, career, recognition of peers, and assuming the common male role of provider for family and decision-maker. Females, allegedly, depend more on love and marriage for life's satisfactions, and their identity may still be associated with male recognition, appreciation, and the roles of wife, companion, and mother. Whether these are biologically determined or socially imposed by a "male-dominated society" needs further study. Considerable research has been done on the association between sex hormones and aggression and/or suicidal behavior.[5-7] Mood and behavior changes in relation to the different phases of the menstrual cycle have been elucidated by others.[8-12] In most species, the male is more aggressive than the female; in both sexes, any given obstruction to goal-directed behavior may result in deprivation. It is suggested that men generally have a stronger aggressive response to frustrating stimuli. Whether the aggressive response results in harm to others or to oneself may depend on other factors.[13] The fact that suicidal girls communicate their suicidal intent more often than boys suggests that girls use suicidal behavior more than boys as a means of manipulating their environment.[14] Men may have stronger aggressive drives, and women may have stronger inhibitions against aggression.

Young white males who cannot find meaning in life and who cannot resolve their aggressive drives may turn to suicide as a solu-

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The first part of this two-part article appeared in the May, 1976, issue.

tion to their depression and anger. The pattern frequently involves the loss of a strong masculine figure with whom to identify. The years of 45-54 for males become a second stressful period of life. These tend to be the years of career disappointment, dream unfulfillment, and remorse. Concern for and loss of children during these years may also add to despair. The third period of stress for white males begins at retirement and continues throughout old age. Inadequate planning for retirement may lead to financial insecurity, loneliness, and anxiety. Retirement in our achievement-oriented society weighs heavily on those who are emotionally unprepared for the freedom of an unstructured life, often complicated by isolation and physical illness. Work is an esteem-sustaining social role, the loss of which is highly correlated with suicidal potential, even in preliterate societies.[15] For some males, retirement may be "work role failure" which had high association with suicide in studies in Los Angeles and New Orleans.[16] The retired male may perceive himself as finished, useless, rejected, with an accompanying feeling of despair, resentment, and rage. Factors of living alone or of social isolation play a common role, as does chronic disease. Chronic illness as a contributing factor to suicide is far more common in the old age group than in young persons. No studies have reported a negative correlation between physical ill health and suicide. Some investigators have found evidence suggestive of positive correlation.[17] Others found no correlation between physical illness and suicide.[18,19] The elderly make fewer attempts but their attempts are more successful than the attempts of younger persons.[20] Some investigators feel that chronic brain syndrome and manic depressive psychosis are the major causes of suicide in the elderly.[21] Others have pointed to the low suicide rate among the elderly in countries where elderly people are valued and respected.[22]

White females tend to suffer distress during the middle years of life when they are most dependent on interpersonal relationships for role satisfaction. Disappointment with husband or children, and lack of satisfying vocation or avocation are factors leading to anger, resentment, frustration, and depression.

Our study indicated that poverty itself is not a significant cause of suicide. More important may be the lack of occupational skills which provide mobility and greater opportunity for jobs and careers. Unskilled workers are faced with seasonal work, lay-offs, and lack of promotional ladders. As the unskilled worker grows older, these factors increase in importance. We suspect that this problem is more significant among the white race due to class attitudes acquired from early family life. Blacks may have learned to cope with this insecurity at an earlier age. The trend of higher suicide rates among black youth in other cities presents a changing pattern. In our community, four of the five black suicides were aged 45 and over. There were no black suicides in 1973 and 1974.

A number of studies have documented correlation between unemployment and suicide among males but not among females.[23-27] Some authors found no correlation between unemployment and suicide, but those are a small minority.[28] Recent reexamination of the data seems to suggest that suicide is more related to loss of job rather than unemployment.[29]

THE role of alcoholism in suicide is not clear. Chronic alcoholics may drink to escape emotional distress but few die only from drinking alcohol. It is apparent that drinking alcohol at the time of intentional injury may be more associated with a predetermined plan for suicide. Alcohol may be needed to gain courage for the act and in some cases to create the impression of an accident. While intoxication is more highly correlated with homocide than with suicide, there is a high correlation between liver cirrhosis and suicide.[30] Many of the "accidental" road deaths could probably more honestly be called suicides or "autocides".

We are tempted to suggest that the true suicidal person has developed a suicide-prone tendency in early childhood and that this tendency continues throughout life. This per-

son[3] is not the usual person who cries for assistance from a suicide prevention center. Characteristically, he seldom learns to seek help. His psychiatric profile must be understood in order to seek him out and provide assistance. Retrospective research should be directed toward interviewing marital partners, friends, family physicians, neighbors, and others who were associated with the person before his death. Such information could lead to a set of suicide predictors and suicide prevention. It may be that the suicide-prone individual learns to adopt suicide behavior in the same way that he learns to adopt coping behavior. He looks for reinforcement in a variety of ways such as talk of death and injury, interest in weapons and accidents, and, perhaps, taking unnecessary risks in hazardous situations. He will seldom, if ever, discuss his depression or his suicide plan with strangers. It is also apparent that the suicide-prone person cannot be differentiated by indices of social status and that available psychological tests, either singly or in combination, offer no prospect of making predictions. We must be careful about falsely labeling cases of potential suicide since there are so few unique signs.

The suicide-prone individual may be a person who by familial and/or hereditary influences reacts to distress by withdrawal. He may commit suicide in youth if he cannot cope with his problems or survive to the next period of serious stress. It is also quite possible for a suicide-prone person to survive his entire life without suicide, if he is able to resolve or avoid stressful situations. Only in this regard do ecological influences become important.

The suicide-prone individual is one with high intent. Intent[3] is defined as the seriousness or intensity of the wish of a patient to terminate his life. Intent is one component of overall suicide risk that includes a conglomerate of other factors, such as access to lethal methods, knowledge regarding the utilization of these methods, and absence of protective individuals in the environment to intervene. The degree of intent is reflected in an individual's overt behavior as a compromise between the wish to live and the wish to die. Thus, we should conceptualize intent as consisting of several major elements, such as the balance between the intensity and the wish to die versus the life protective wishes and the patient's estimate that his suicide plan or wish will result in death. Scales designed to measure intent should be developed from death certificate information and a subsequent psychiatric profile.

The method of death certification varies so much among the states that indiscriminate comparisons are bound to be misleading. The difference is considerable between the criteria on which the coroner bases a suicide verdict and those underlying the diagnosis of death by suicide made by a doctor. Obviously, we should press for the certification of suicide being entirely freed from its association with the criminal law and made a medical responsibility with proper safeguards. We should aim at uniformity of certification procedures and the adoption of common operational criteria for case finding. We recommend a crash program to upgrade and improve all certifying, investigating, and reporting procedures. These would include national standardized criteria for types of cases to be seen by coroners' offices, standardized indications for performing autopsies, standardized toxicological testing, the use of psychological profiles for equivocal cases, training of legal and medical investigative personnel concerned with certification of suicide death, modification of "legal presumption against suicide", a change in procedure to insure confidentiality regarding the manner of death and opinion as expressed by the certifier, and improved hospital emergency room record-keeping and reporting of suicide attempts and deaths.

It is not implied that the problem of suicide prevention is all one of identification. Treatment, or assistance, or befriending must follow identification.[4] We must also address research into followup and new treatment approaches. A most serious difficulty is the failure of most people to differentiate between management of the acutely suicidal and the chronically suicidal person. Crisis intervention techniques

are designed for the former but much less attention has been paid to the latter group, from which recidivistic suicide attempters and completers are primarily drawn. The use of volunteers, outreach programs, family therapy, "gatekeeper" programs, and other approaches need careful evaluation.

When a person is in emotional crisis, to whom does he turn for help? Who would be the most significant "gatekeepers" for suicide-prone persons? Research[4] so far has found that family, friends, clergymen, and physicians represent the important gatekeepers, but their work needs to be evaluated further. The recognized need here is to motivate the suicidal person to return to useful social life, utilizing his own environment as much as possible. Help is best given on a person-to-person basis rather than utilizing institutions, hospitals, or social agencies.

In principle, and given the necessary knowledge, anyone at all who is in a position to observe changed behavior, deteriorated circumstances, or the communication of suicidal thoughts could function as identifier of high risk persons. Nonprofessionals who answer calls to crisis centers are examples of this. It is not their fault that the self-selection of callers results in a low yield. Persons thinking seriously of suicide rarely call.

About half of suicide cases[3] have consulted a physician within a year or less of the act. Further investigation will need to show whether suicides under medical care represent that small proportion of high risk patients whose risk potential is somehow overlooked amidst a generally high level of comprehensive care, or whether there is broad failure on the part of physicians to address themselves to the questions of psychiatric diagnosis and risk evaluation.

Conclusion

The usefulness of this study, in our opinion, has been to narrow the field of research in suicidology toward identification of the true suicide-prone person. Research should begin with a revision of the death certificate for suicides as the beginning of retrospective studies needed for solutions. Serious longitudinal studies of the lives of suicide-prone individuals should be undertaken. Multiple regression analysis would seem to be one tool of trial use. Next, demographic predictors may be more useful than psychological predictors in helping to plan programs. Needed is a good taxonomy of suicidal types, as well as a good deal of information about the psychological characteristics of the suicidal individual.

Different populations may require different sets of predictors, and only by broadening basic data can the possibilities be extended. Thus, one should seek details, for example, of family structure, living circumstances, and of change in the pattern of such items as marital status, religious affiliation, or occupation. Although this will require large samples to make it useful, there may be no other way to develop needed flexibility in assessing persons of varied social and psychological subcultures.

Our study supports previous research indicating that potentially suicidal persons at highest risk tend to be those who have been chronically suicidal, have made repeated attempts, or who have had long-term suicidal ideation, and in whom stress and symptoms are not dramatic except for chronic and recurrent depression.

Obtaining accurate death certifications must be the first step in conducting retrospective research which will lead to sets of predictors designed to prevent suicides.

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Calendar of Medical Events, 1976

June

Annual Convention—Seaboard Medical Association—Holiday Inn at Kill Devil Hills, Nags Head, North Carolina—June 17-20.

The Art and Science of Sports Medicine—Sponsored by University of Virginia, Departments of Orthopedic Surgery and Rehabilitation, Health and Physical Education, and Athletics, in cooperation with The Medical Society of Virginia—University of Virginia—Charlottesville—June 23-26.

Annual Convention—American Medical Association—Dallas, Texas—June 26-30.

September

Diabetes 1976—Sponsored by Division of Endocrinology and Metabolism and Department of Continuing Education, MCV—Medical College of Virginia, Richmond—September 23.

Letters . . . .

To the Editor: I wish we did not have to talk anymore about PSRO's, but we can be as negligent by omission as by commission. What prompts me to write are two letters from the chairmen of two of the five PSRO's in the state; in both of them I am asked to support the status quo, in contraposition to one PSRO for the entire state. One argument given is that five voices carry more power than one. I do not subscribe to that theory. Five mice do not make more noise than a lion! Another argument is that we have already spent too much money organizing the five separate PSRO's. What is wrong with having one PSRO with five regional groups? In that manner we keep the organizations and the expertise, but have a united membership.

Let's face it—the hour is late and the opportunities minimal. Let us do our best to prove that the doctors of the Commonwealth speak with a single voice. In the year of the Bicentennial, to paraphrase one of our patriots, we hang together or we hang separately.

I urge support of the Council and go on record for a single PSRO.

Anthony J. Munoz, M.D.

420 East Third Street
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Dispirited? The Editor Recommends:

For those of you who are discouraged or unduly apprehensive about the state of American medicine, let me suggest that you brighten your day by reading "The Case for American Medicine", with the subtitle "A Realistic Look At Our Health Care System", published by David McKay Compant, Inc., New York. The author, Harry Schwartz, is highly qualified to write on this subject, and his well documented presentation of the state of American medicine as he sees it will hearten you. Although the book was published in 1972 it is as pertinent in 1976.

W.T.T.

Editorial....

Sleep-- Some Observations Relative Thereto

"It makes the shepherd equal to the monarch and the fool to the wise."
—Cervantes

THE condition or state of sleep has been a subject upon which philosophers poets, pundits, authors, and clergymen have liked to dwell. The physiological principles accountable for its occurrence and essentiality have for long constituted a challenge—particularly to physiologists and psychologists.

There is no sustitute for sleep, and it is common to all forms of animal life. A kind of sleep is, moreover, apparent in the vegetable world. Petals or leaves of certain shrubs and trees assume a different position at night. To this peculiarity botanists assign the term, nyctitropism.

With the majority of animals, sleep is a nocturnal habit. Some however, sleep by day and prowl by night. The cat family—including lions—is so disposed. For man, and nearly all animals, the horizontal position generally is chosen for sleep, but some animals sleep in either a standing or lying position. Bats hang head downward.

Beyond observing that hibernation and aestivation are said to occur in every group of vertebrates (save birds), and predisposing causes, both immediate and remote, are by no means uniform, these aspects of sleep—though fascinating—will be accorded little more than mere mention.

Here, albeit, I would stray afield to the end of making an observation with respect to the exception ascribed to birds. It does not appear unreasonable to consider that, in lieu of hibernating, birds migrate—but not uniformly so. Robins and purple martins are classical migratory birds, while cardinals and jays remain in the same environs the year round. A singular oddity applicable to the mocking bird is worthy of mention. A pair of this species separates in autumn, and the female departs. The male mocking bird remains throughout the winter to guard their erstwhile, and contemplated future, nesting site. At least this, according to the explanation offered by experts in ornithology, is why the male mocking bird does not accompany his mate to Florida. Their antics upon reuniting the following spring rival those of the albatrosses or "goony" birds on Midway Islands.

Researchers, imbued with an extraordinary penchant for determining a plausible solution to the phenomenon of sleep, have pursued several courses and half a dozen theories have been advanced. The courses followed have been founded 1) upon observational data, 2) upon experimental data, and 3) upon theories. The theories of sleep have encompassed a) circulatory factors (blood circulation); b) inhibitory influences (widespread inhibition); c) the principle of deafferentation (shutting off incoming, proprioceptive, sensory impulses); d) a biological basis (according to which sleep is considered an instinct); e) humoral or chemical processes (modification of metabolic elements); f) an evolutionary theory (an attempt to distinguish between the re-

lationship of the hypothalmic centers and the cortical centers). None of these theories has been universally accepted.

Shifting from the scientific aspects of sleep and an admission that its cause, its physiological dynamics, its modus operandi, or "howcome" has remained one of the "sweet mysteries of life," it would appear in order to turn to the role sleep has played in prayer, in literature, in nursery or juvenile tales and in mythology.

Because it doubtless has been repeated millions of times at the knee of millions of mothers or fathers, it seems appropriate to begin with the prayer: "Now I Lay Me Down To Sleep." This guileless and humble bedtime prayer is said to have first appeared in *The New England Primer*, edited during the 18th century by Benjamin Harris. In the earliest edition of the *Primer*, the first line of this prayer appeared as: "Now I lay me down to take my sleep." In the edition of 1784, it was changed to read: "Now I lay me down to sleep." And in the 1814 edition, the second line had been rectified to read: "I pray *thee*, Lord, my soul to keep."

Next, may it suffice to note that fictionally the duration of sleep has varied widely. As a decisive factor in the outcome of the race between the tortoise and the hare, as recorded in *Aesop's Fables*, sleep was not necessarily of more than brief duration. A comparable estimation may be made relative to "Little Boy Blue." In Andersen's fairy tale, "The Princess And The Pea," sleep—or its inhibition—during a single night played a dominant role. (Within relatively recent years, this tale was converted into a musical comedy, entitled: "Once Upon a Mattress"). In James Henry Leigh Hunt's "Abou Ben Adem," sleep for a part of two consecutive nights sufficed. In *Alice's Adventures in Wonderland*, the dormouse was no piker at napping. (Incidentally, that dormice actually are classed as hibernators extraordinary is thought to merit mention. Six months is that animal's conventional hibernating period.) In his book entitled *Looking Backward, 2000-1887*, Edward Bellamy, a 19th century novelist, portrayed Julian West, a fashionable young Bostonian, as having remained in a hypnotic state from 30/May/1887 to the year 2000, a span of 113 years, before he was awakened by Doctor Leete, between whose daughter and Julian quite a romance is depicted as having burgeoned and flourished. Washington Irving gave Rip Van Winkle a 20-year slumber. Der Alter Barbarosa—Der Kaiser Frederick is alleged to have slept at 100-year intervals between his exits from beneath his mountain to determine if the raven was still in flight thereabout. In "La Belle au Bois Dormant," Charles Perrault allocated 100 years to the "Sleeping Beauty" before the handsome young prince penetrated the hitherto supposedly impenetrable forest that had grown up around her castle and awakened her with a kiss. From that nursery tale, Tschaikowsky rendered a ballet score. A prototype of Perrault's story is extant in the sleeping Brynhild and her rescue by Sigurd. This reckoning leads back to Epimenides, a Cretan poet, who, according to legend, slept in a cave for 57 years. Further back still, we come to the seven sleepers of Ephesus who, incident to the persecution instigated by the Roman Consul, Decius (340 B. C.), in a state of divine sleep stayed walled in a cave for 230 years. The most pathetic sidelight of this myth relates to the faithful dog that remained standing and on guard during the long term of imprisonment of his friends.

Among the scores of writers, poets, and notables of literature who have

keynoted sleep and have accorded it honorable mention or top billing, most, I think, will agree that this list should be headed by Shakespeare—the world's nonpariel master of the English language. In *King Lear* this paragon of scribes wrote: "Our foster nurse of nature is repose." In *Cymbeline* he declared: "Weariness can snore upon the flint, when restive sloth finds the down pillow hard." In *Macbeth*, Shakespeare made several references to sleep: "Sleep shall neither night nor day hang upon his pent-house lid." . . . "Downy sleep, death's counterfeit." . . . "Methought I heard a voice cry, 'Sleep no more! Macbeth does murder sleep!' the innocent sleep, Sleep that knits up the ravell'd sleave of care, The death of each day's life, sore labour's bath, Balm of hurt minds, great nature's second course, Chief nourisher in life's feast." All are quotations from *Macbeth*. The last is a frequently quoted Shakespearean excerpt. Nevertheless, in terms of frequency of common reference, it is unlikely that the ravell'd sleave of care citation surpasses the Bard of Avon's awesome focus upon sleep in Hamlet's soliloquy.

Withal, if a comparison of the talent of the old masters of literature to impart a quality of morbidity to the element of sleep is a desideratum, one would need hearken back 2,000 years preShakespeare, to Sophocles, and his "Chorus from Ajax":

> "When reason's day
> Sets rayless—joyless—quenched in cold decay,
> Better to die, and sleep
> The never waking sleep, than linger on,
> And dare to live, when the soul's life is gone."

It was this passage that James Forrestal had underlined in the open book he left on his bed preliminary to hurtling to his death from a window high in Bethesda Naval Hospital's tower.

In "The Ancient Mariner," Coleridge wrote: "Oh sleep! it is a gentle thing, Beloved from pole to pole." A "Note-Book" of Leonardo Da Vinci contains the observation: "As a well-spent day brings happy sleep, so life well used brings happy death."

Finally the extent to which sleep is accorded respect by pharmaceutical manufacturers comes to the fore. Under the headings of analgesics, sedatives, and hypnotics, the 1975 edition of Physicians' Desk Reference lists approximately 230 medicaments. Still, under no category do such well known sleeping aids as the antihistamines, particularly benadryl, appear.

At any rate, over two decades ago, after having surveyed 600 products for sale in a New York City "sleep shop," Ogden Nash wrote a travesty on sleep titled, "What! No Sheep?", of which this is the climactic stanza.

> "Evenins, when the sunlight westers,
> I pity my poor pioneer ancestors.
> They rode the wilderness wide and high,
> But how did they ever go sleepy bye,
> Without their eye shade,
> Their clock radio,
> Their sleep record,
> Their vaporizer,
> Their sinus mask,
> Their electric slippers,
> Their yawn plaque,
> Their slumber buzzer,
> Their massagin pillow,
> Their snore ball,
> Their minature electric organ,
> An their wonderful electric blanket?"

H. Lamont Pugh, M.D.

Guest Editorial....

Shock and Shakespeare

SYNCOPE[1] caused by a multitude of factors may have a common precedent expression mediated via the autonomic nervous system—vagal, or sympathetic, or both in varying proportions. Sensitive writers such as Shakespeare have recognized "cold body" as an indicator of shock or predeath state. "As cold as any stone"—so the Hostess describes Falstaff's body in *King Henry V*.

This autonomically mediated response is also called into play in very early stages of a variety of stress states (preshock), comprehensively described by Cannon[2] in wound shock.

However, before a full picture (as described by Cannon) appears, skin over the nose, malar area, helix of the ears, dorsum of the hands and feet, fingers and toes—not necessarily in sequence—feel detectably cooler than other parts of the body, or the skin over the nose, forehead, and malar area feel cool and moist. Presently, it is believed that the skin over the nose, malar area, and helix exhibits coolness earlier. This may be a phasic or transient event.

Observation and noninvasive monitoring of this nice and simple phenomenon, intra- and post-operatively[3] and in other stress states, offers a sensitive, early index of impending shock states. If "warming up" does not occur reasonably early, then further thought dictated by the clinical situation is warranted. If appropriate measures are not taken early, then more dramatic and popularly known signs of shock—plummeting blood pressure; fast, feeble pulse; profuse sweating; cool skin over most of the body area—are evident as a late expression.

There is an appreciable time interval between early (preshock) and late stages to allow appropriate measures to prevent sequential vital organ impairment.

Recent experimental investigations[4,5] of unit neuronal activity and associated cardiovascular changes may offer further elucidation of the underlying mechanism.

SARVOTHAM S. DHUNDSHY, M.D.

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Obituary . . . .

Nathan Bloom, M.D.
Richmond

Nathan Bloom died at his home in Richmond on December 9, 1975, at the age of 71. He was born on January 25, 1904, in Montreal, Canada, and moved to Richmond with his parents in 1905. He was educated in the public schools of Richmond and was graduated from the School of Pharmacy, Medical College of Virginia, in 1925. As an undergraduate, he was elected to membership in the Rho Chi Honor Society. Subsequently, he entered the School of Medicine, Medical College of Virginia, from which he graduated in 1932. He interned at the Medical College of Virginia Hospitals from 1932 to 1933 and was a member of the medical resident staff from 1933 to 1936. He held the position of Chief Medical Resident during the year 1935-1936.

After completing his training, he established practice in Richmond in general internal medicine, with special emphasis on cardiovascular diseases. He continued his association with the Medical College of Virginia on a part-time basis, beginning as an instructor in medicine. Subsequently he was promoted to assistant professor of clinical medicine, and in 1954, was appointed professor of clinical medicine. He was chief of the electrocardiographic laboratory at the Medical College of Virginia Hospitals from 1938 until 1960. Thereafter he continued his active interest and participation in the laboratory until his retirement from the faculty in 1969. In 1943, he was elected to membership in Alpha Omega Honor Society. Dr. Bloom served the Medical College of Virginia with untiring efforts, particularly during the earlier portion of his academic career. He was actively involved in the undergraduate and graduate teaching programs. His special efforts in taking along students and house staff alike, as he made rounds on his private patients, is especially noteworthy. He was an effective and graphic teacher, beloved and respected by his students. He also spent much time, thought and energy in developing the electrocardiographic laboratory from rather meager beginnings to a service operation of considerable magnitude. He was an avid student himself and was imbued with the desire for continuing self-education. He contributed many articles to the medical literature and was coauthor of a textbook on electrocardiography.

Dr. Bloom served his community as a dedicated physician. Although a cardiovascular specialist, his forte was the practice of general medicine. His rapport was immediate and long-lasting. His self confidence reassured his patients that he could solve most any problem, and his warmth eased the way for those whose problems proved to be insurmountable. He was a dear man.

Dr. Bloom was married to the former Miriam Alperin, who died in 1967. They had one adopted son, Howard Bloom, who was killed in a helicopter crash in 1974. In 1969 he married the former Inda Hoffman, who survives him. He also is survived by one grandson.

Therefore, be it resolved that this resolution be recorded in the minutes of this meeting and that a copy be sent to Dr. Bloom's family.

David J. Greenberg, M.D.
Howard McCue, Jr.
Reno R. Porter, M.D., *Chairman*

Jacob Charles Harshbarger
Harrisonburg

On November 8, 1974, Dr. Jacob Charles Harshbarger, a general medical doctor for 46 years, died at his home in Harrisonburg, Virginia.

Dr. Harshbarger was born December 16, 1900, at Port Republic, Virginia, and was a son of Dr. C. P. and Betty Long Harshbarger. He attended elementary school at Mill Creek and Victory Hill and secondary school at Bridgewater Academy. In 1922 he graduated with honors from Bridgewater College to go on to the University of Virginia, where he re-

ceived his medical degree in 1926. He was a member of the Alpha Omego Alpha and the Phi Beta Pi fraternities. He interned at Walter Reed General Hospital and graduated from the Army Medical School in 1928, after which he was commissioned as a captain in the U. S. Army. In 1928 he came to Harrisonburg and started his practice of medicine. He held membership in the American Academy of General Practice, American Medical Association, Southern Medical Association, Virginia Medical Society, and the Rockingham County Medical Society. He was also a member of the Harrisonburg Rotary Club.

In 1926 he married Patience Cline Harshbarger, who survives him. He had one daughter and two grandchildren.

Dr. Harshbarger's contributions are those of a quiet, unassuming, and deeply religious physician. He has a lifelong member of the Church of the Brethren and served as a deacon. He was dedicated to service and administered to medical needs of his fellowman, so often with only personal satisfaction as his reward. For his services he was named the first recipient of the Exchange Club Book of Golden Deeds award. His hobbies of farming and gardening were never really pursued because he was "always available". This gentle man seemed to be above any expressions of impatience or anger and service seemed to be instinctive. He is greatly missed by colleagues, his family, and his patients.

Therefore, be it here resolved that his name be spread on the records of the Rockingham County Society records and that a copy of this be sent to his family and to the Medical Society of Virginia.

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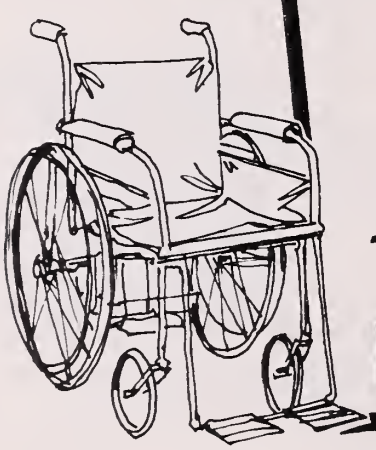
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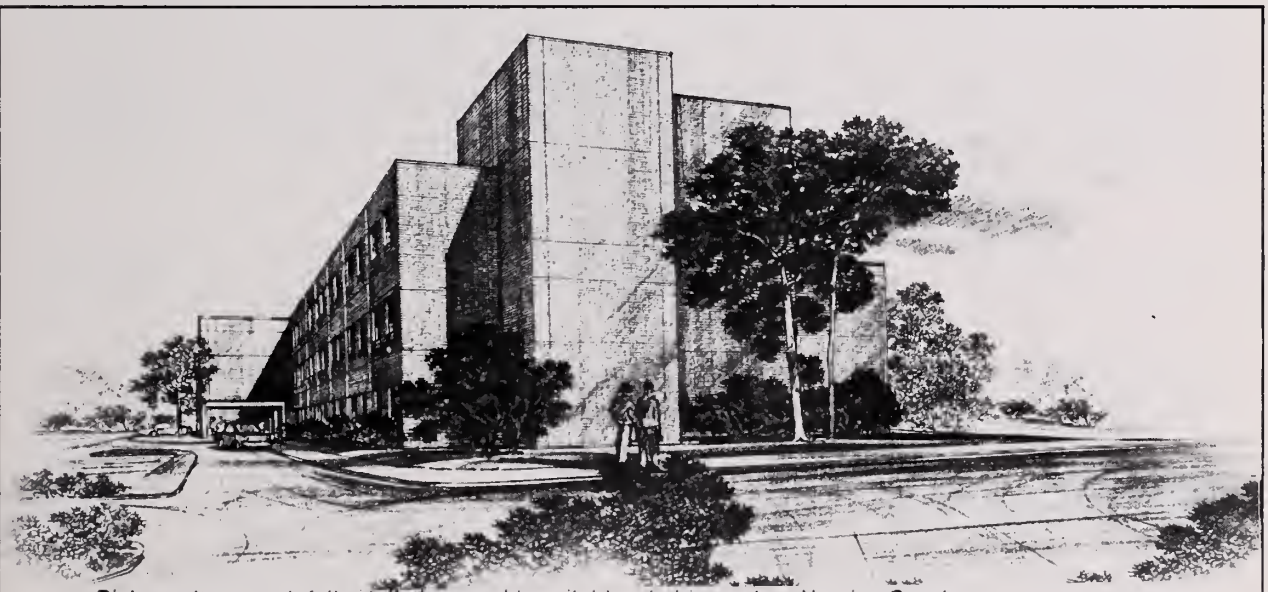
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News . . . .

A Michigan MD Committee Assails the Insurance Industry

In a sharp indictment of the insurance industry's role in the medical malpractice situation, a group of 1500 Michigan physicians has filed a petition with their state insurance commissioner demanding vast reform and stricter regulation of companies writing malpractice insurance in Michigan. The physicians are members of the Physicians Crisis Committee, headquartered in Detroit.

Their massive, 55-page petition pulls no punches in demanding full disclosure of the insurance industry's income, expense, and profit and loss, in order, the petition states, "to establish legitimate rate-making and underwriting practices." The petitioners charge the industry with "misleading the public and Michigan doctors by withholding the truth about the enormous profits made by the industry as a result of the malpractice crisis" and with "realizing an unreasonably high rate of return from insuring physicians (while claiming the opposite)."

The petition cites the profits of Medical Protective, Michigan's dominant casualty carrier, which earns its total income from writing malpractice insurance for doctors and dentists. "For the 10-year period 1965-74, Medical Protective's average total profit was 24.2% after taxes," the petition asserts. "During the last five years of that period, when the crisis was escalating rapidly, its after tax profits were even higher—a startling 29.1% of net worth." Yet, says the petition, the company reported "underwriting" losses during that period—and was granted a rate increase, raised premiums, and lowered coverage limits.

Further, states the petition, "during 1975, when the industry was crying the blues about underwriting losses, recession, and inflation—reasons given to justify either raising doctors' insurance premiums or deserting the market—Medical Protective increased its before-tax profits from $3.68 million in 1974 to $5.58 million in 1975, an increase of more than 50%."

Virginia's primary malpractice carrier, St. Paul Fire and Marine, is cited by the petition as the only company that has supported legislative efforts to institute medical arbitration or to upgrade the regulation of medicine itself. All other companies, the petition states, have been "consistently unwilling" to support efforts of this kind. Why? A spokesman for the petition offers this explanation. "First, high profit levels can be attributed in part to long delays between pay-in of premiums and pay-out of claims," for this makes possible a very high level of investment income. Arbitration would reduce that delay "from nearly five years to one year," with corresponding reduction of income earned on reserve monies.

Describing insurance companies who "fled the state," the petition says they did so not for lack of profitability, but because of their exasperation over the unpredictability of claims and of what might happen to future profits. "They took the money and ran," charges the petition, "despite the fact their leaving could have forced a large scale withdrawal of medical service" had it not been for the creation by the state of a physicians insurance fund.

"If left to its own devices, the insurance industry will continue to profit enormously," the petition concludes, "charging higher premiums and receiving even larger profits in years to come, at the expense of the public and doctors. The petitioners and the public have the right to demand that the insurance industry make full disclosure and accept malpractice insurance regulation that assures the premiums charged are not excessive, that the profits made are no longer unreasonable, and that policies are administered without discrimination and in the public interest."

In response to the document, Michigan's insurance commissioner indicated he would schedule hearings to gather evidence concerning the petition.

"We are a Litigious People": The President's Consultant

The malpractice crisis "would seem to be a phenomenon of the United States. We are a litigious people [with a] great tendency to blame someone else." These words were attributed to Dr. Roger O. Egeberg, special consultant to the President on health affairs and special assistant for health policy at HEW, by the *Richmond Times-Dispatch* recently in the report of a speech by Dr. Egeberg at the 16th annual Law Institute on Hospitals and Medicine. "Almost everybody now has to worry about increasing liability," Dr. Egeberg was quoted as saying, as he referred to the growth of malpractice suits in all professions.

As for medical malpractice, Dr. Egeberg suggested that possible malpractice incidents occurring in hospitals ought to be reported immediately to appropriate officials, as one way to attack

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the problem. He referred to one university hospital where, if a malpractice case comes up and the original incident was not reported to hospital authorities, the doctor involved is likely to be discharged from the staff.

"It's hard to do, but doctors do need to report possible cases," said Dr. Egeberg, adding that bad doctors or practices "are not being caught early enough." He warned, according to the *Times-Dispatch*, that policies similar to the one cited must "come to all hospitals".

Dr. Egeberg offered these additional routes of attack: a "realistic look at the statute of limitations" a graduated scale for contingency fees; the elimination of filing for specific amounts of money; mediation panels.

The institute at which Dr. Egeberg spoke was sponsored by the Medical College of Virginia's departments of hospital and health administration and legal medicine, in conjunction with the Virginia Hospital Association.

The Malpractice Infection Spreads to the Law

The national news media has reported recently an acceleration of malpractice suits in yet another profession, the law. Legal malpractice litigation is increasing sharply, that's the message, and a curious one it is, for it pits lawyer against lawyer. Amounts of settlements and awards are climbing, too. Some lawyers say it is as critical a time for them as it is for physicians. They predict that malpractice suits against engineers, insurance agents, architects, builders, and others will be next.

A lawyer who has researched legal malpractice in Virginia is Duke Nordlinger Stern. He is the author of an empirical study, "The Virginia Attorney Malpractice Experience, which appeared in the Virginia Bar News of May, 1974. At that time Mr. Stern was special consultant to the Virginia State Bar; he is now executive director of the West Virginia State Bar, Charleston. He has written a book, "An Attorney's Guide to Malpractice Liability," to be published this spring by the Michie Company, Charleston.

For his survey, Mr. Stern mailed questionnaires to the more than 6,000 members of the Virginia State Bar asking for their experience during the period 1963-73. This produced 1,449 questionnaires usable for analysis. Of this group, 197 Virginia attorneys reported their firm had experienced a malpractice claim. About a fifth of these had more than one occurrence; indeed, two of them had experienced five or more occurrences, the study relates.

As for settlements, the Virginia study showed a large proportion (110 lawyers) had paid claims of $15,000 or less, which was little comfort to the six attorneys who had paid losses in excess of $75,000 each. A significant number (21 lawyers) reported paying claims in the $25,000-$50,000 bracket.

What did these malpractice suits charge? Mr. Stern lists "running" of statutes of limitations; inadequate docket control (like a surgeon scheduling too many operations); faulty title search; faulty deeds; faulty drafting of wills and trusts; incorrect advice to client; improper handling of client's funds; improper litigation procedures; fraud; acts and omissions of partners and associates; acts and omissions of employees. In the Virginia study, distribution was fairly even over these causes.

Like physicians, attorneys are having a tough time with malpractice insurance. Physicians who resent having to purchase claims-made policies should know, Mr. Stern tells this journal, that all legal malpractice insurance will soon be the claims-made type. Two companies have offered occurrence policies to lawyers in the past, but they are cancelling them this year.

* * * * *

Obstetrician-gynecologists have the disastrous distinction of taking first place in another one of those surveys sorting out medical malpractice suits by specialty. This most recent one, as reported in *Ob/Gyn News*, was made by the American Insurance Association and analyzed the data of claims closed in 1974. It gives the nod to ob/gyn as the most sued specialists, with surgeons coming in a very close second.

Commenting on the survey, Dr. Ervin E. Nichols, director of practice activities at the American College of Obstetricians and Gynecologists, is quoted as pointing out that members of his specialty are subject to dual jeopardy, infant and mother, a situation not present for other disciplines.

* * * * *

From the Department of the Army at Fort Lee comes the following notice:

All CHAMPUS beneficiaries who live within 40 miles of a military treatment facility or public health service hospital must seek nonemergency inpatient care at that hospital. The beneficiary may be a dependent of an active duty member, survivor of deceased active duty member, retiree, dependent of retiree, or survivor of deceased retiree. Depending on circumstances and care available, the hospital may issue a nonavailability statement which would allow the patient to seek the needed care from a civilian source.

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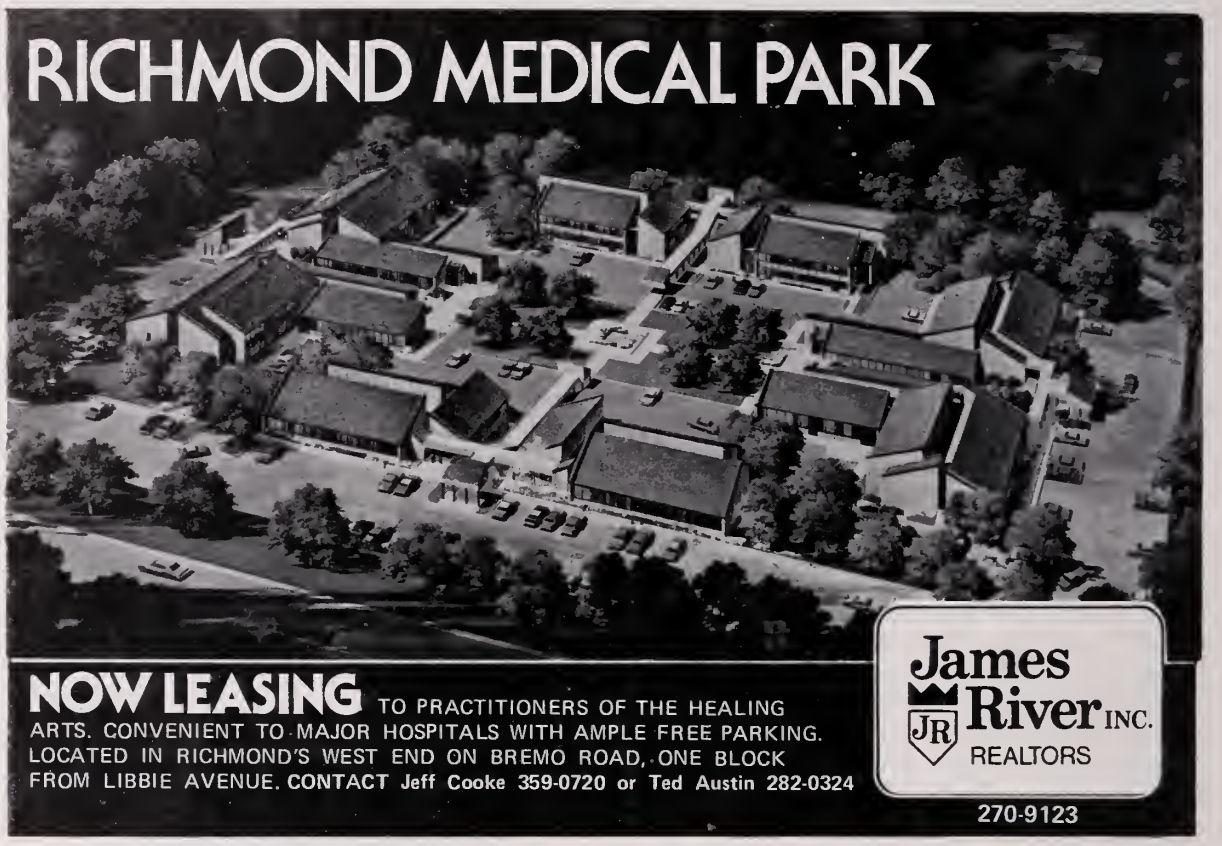
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TOYOTA

Questions relating to the treatment of alcoholism are to be added to the medical licensing examinations used in Virginia and all other states, according to a report from the National Clearinghouse for Alcohol Information of the National Institute on Alcohol Abuse and Alcoholism. The questions are to be submitted each year by the National Council of Alcoholism, one of the organizations that has pushed for their inclusion. The National Board of Examiners made the decision to include the questions. The new requirement is expected to provide impetus for development of alcoholism components in medical school curricula.



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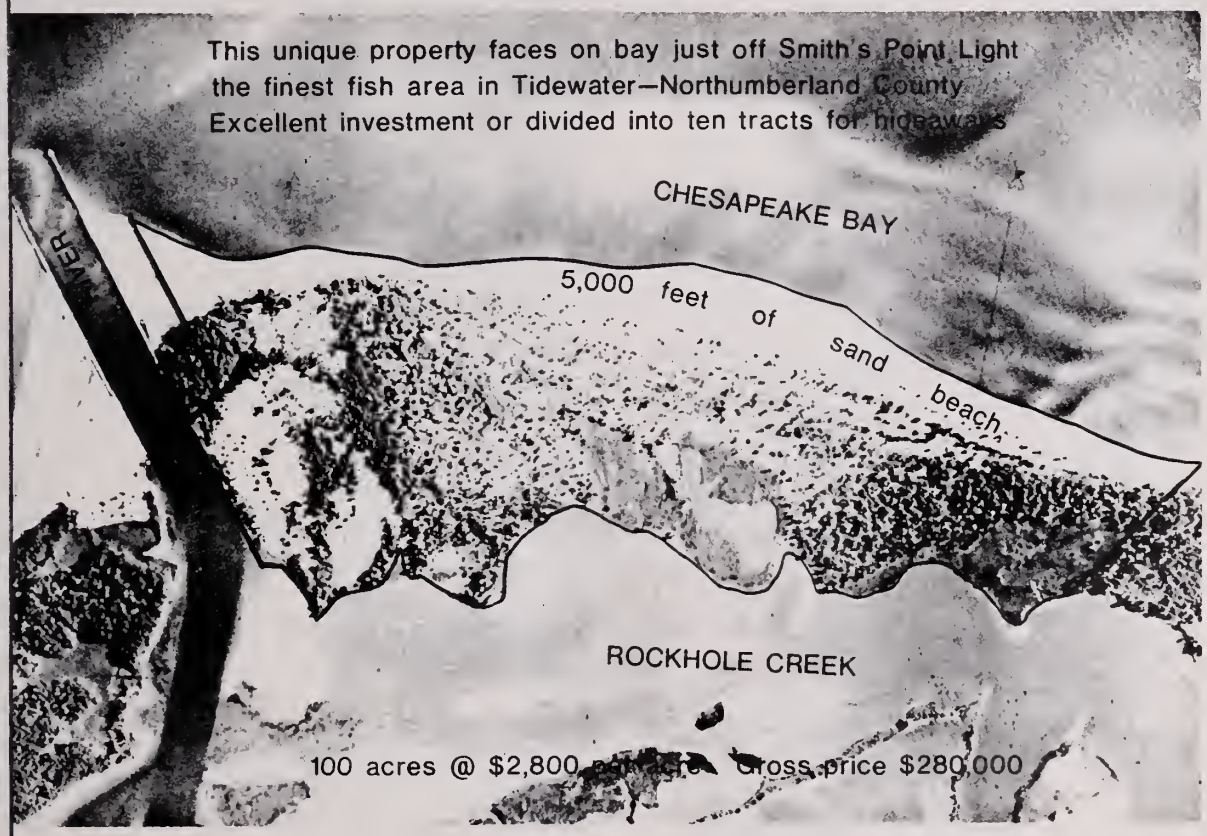
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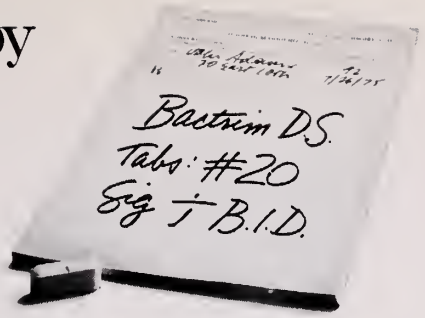
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In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (*e.g.*, vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

Bactrim™
(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

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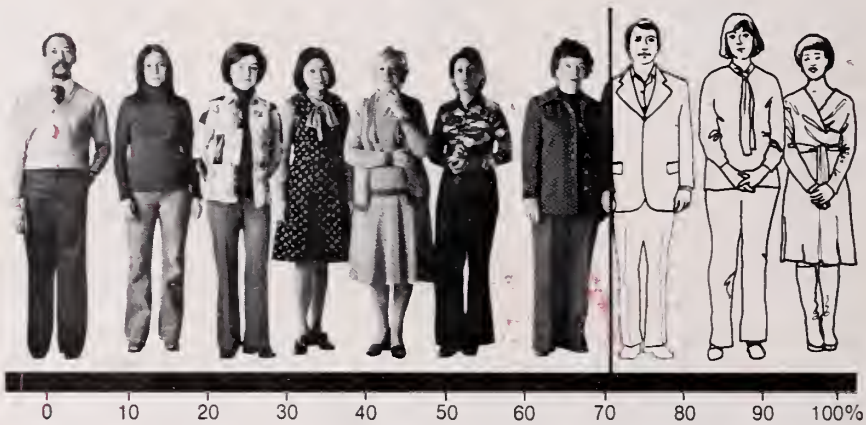
In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†

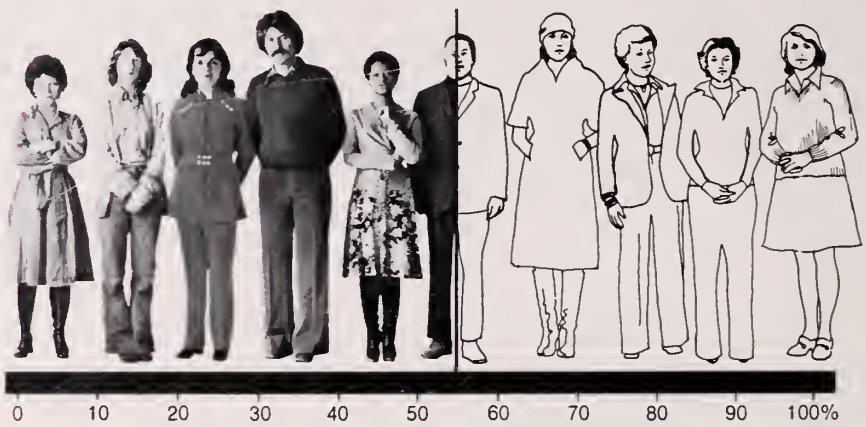
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Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

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The Council Meets for Key Decisions

Vol. 103
JULY
1976

Both often



Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequen and/or severity of grand mal seizures m require increased dosage of standard an convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous in gestion of alcohol and other CNS depres sants. Withdrawal symptoms (similar to those with barbiturates and alcohol) hav occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

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m is pronounced and
This means that im-
ment is usually apparent
in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

lance because of their predisposi-
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n. Usual precautions indicated in
s severely depressed, or with latent
sion, or with suicidal tendencies.

Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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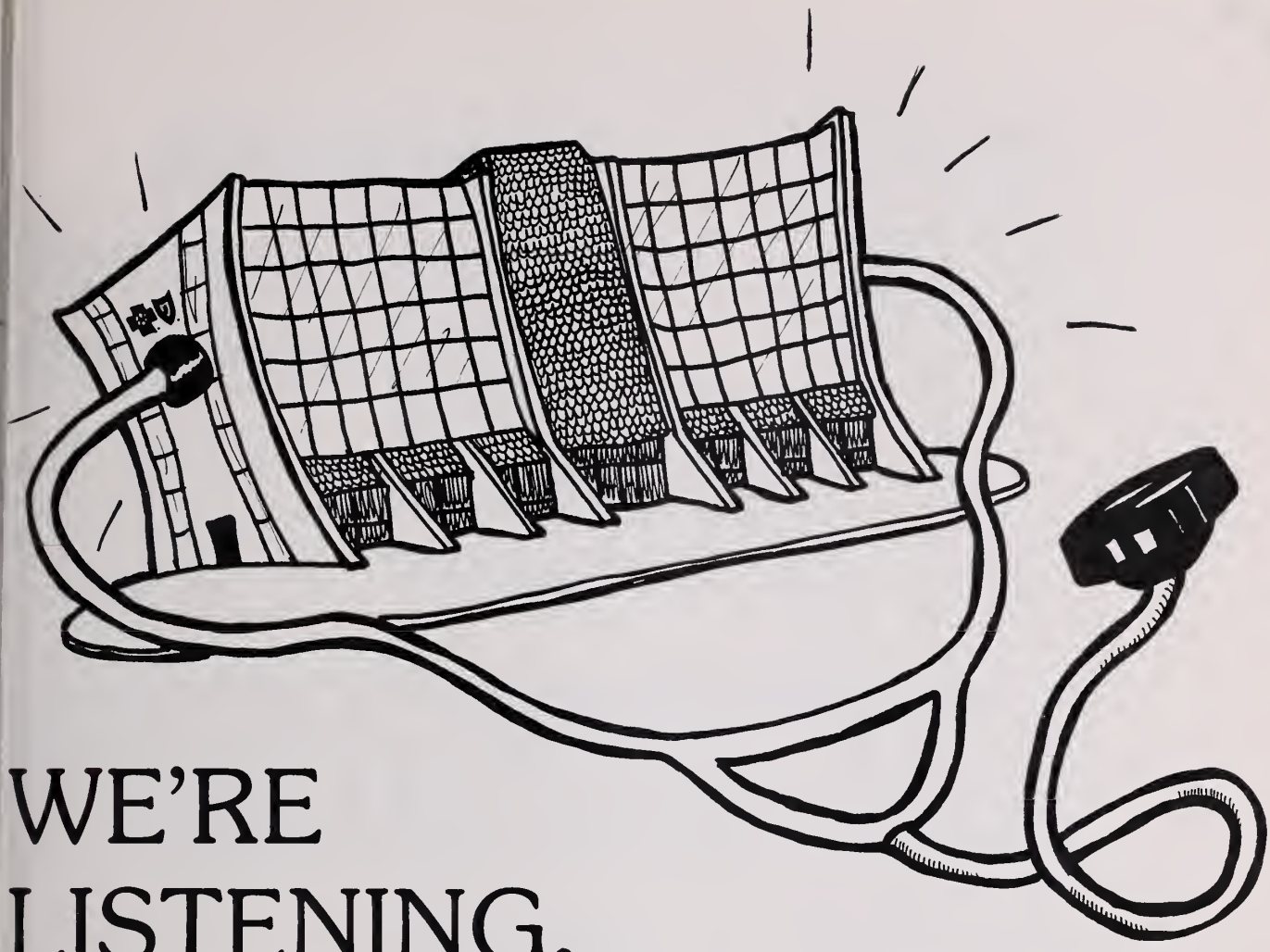
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We're listening.

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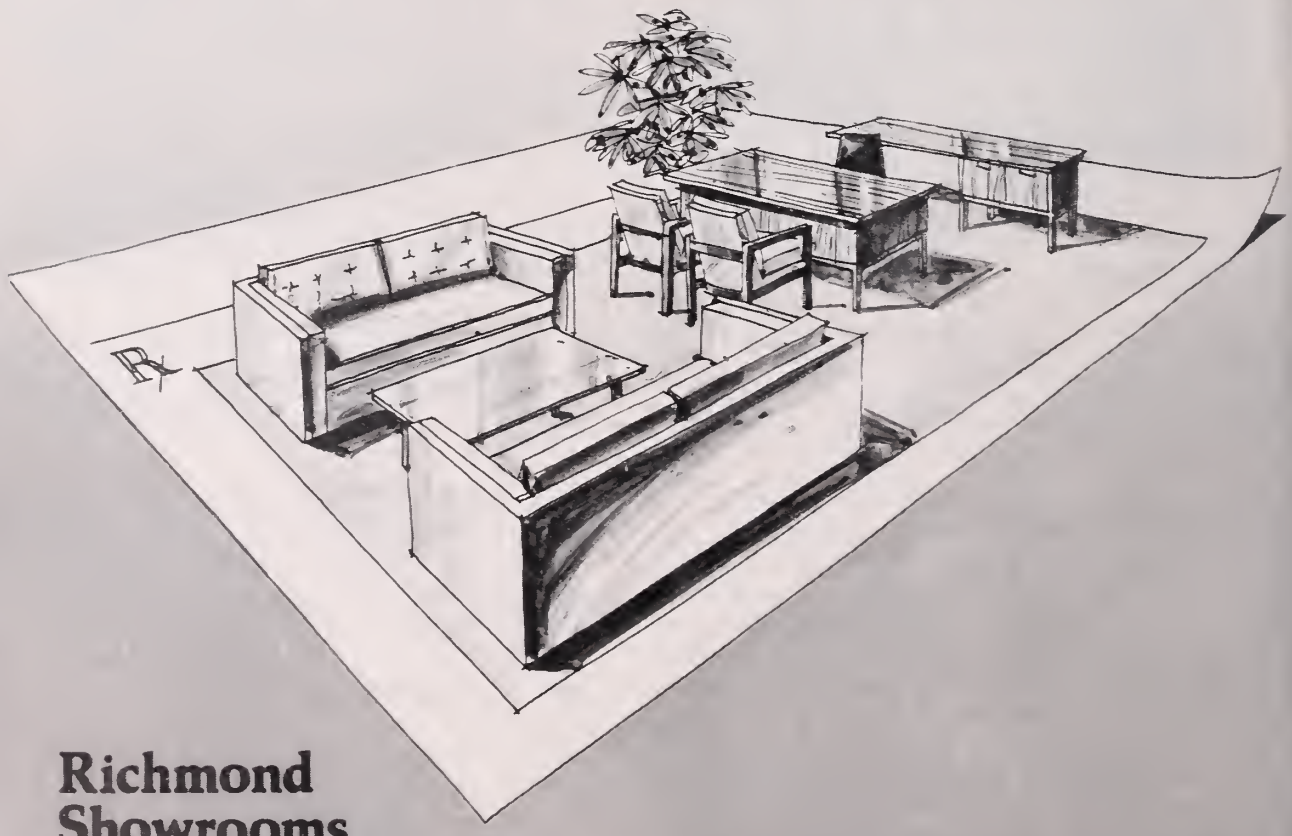
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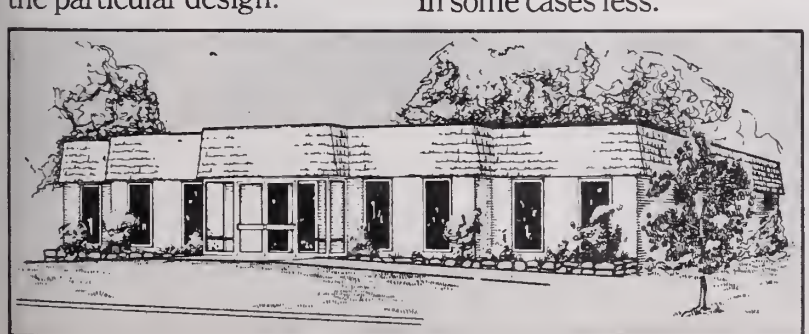
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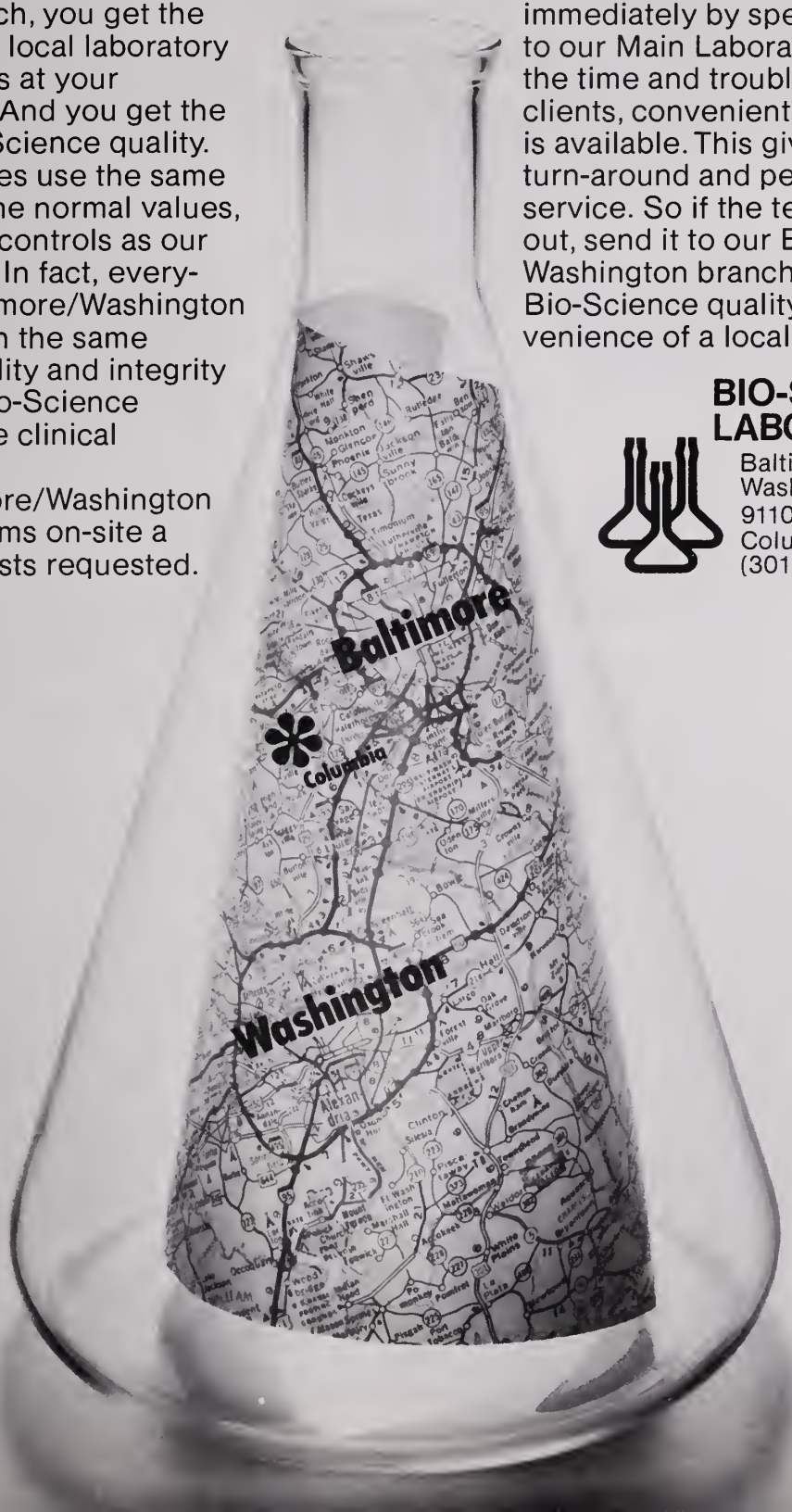
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(Founded by Landon B. Edwards, M.D., April, 1874)
PUBLISHED MONTHLY BY THE MEDICAL SOCIETY OF VIRGINIA
4205 DOVER ROAD, RICHMOND, VIRGINIA 23221

Happy Birthday to America! Happy Birthday to Us!

ALL periodicals worth their patriotic salt, medical journals not excepted, will make some special mention of the Unique Fourth, not just the Glorious Fourth, that occurs during this July of 1976. The exact hour and day of the birth of a country can hardly be determined with the same precision as that of a human birth; but, by all accounts, it was in the afternoon of the 4th of July of 1776 that the final signatures were affixed validating our Declaration of Independence and signalling the Birth of a Nation.

Interestingly enough, the Centennial Fourth was allowed to pass without comment by our Virginia Medical Monthly. A careful perusal of the July, 1876, issue reveals no mention of the 4th of July or reference to the Centennial year. There were papers dealing with instrumentation of the genitourinary tract and with the merits of ergot and of quinine. There were lively matters discussed in Letters to the Editor, and the Editorial was concerned with medical ethics. Shades of things to come! All of these declarations were quite topical, but there was no trace of anything historical. Perhaps the death of the Confederate States of America was still too recent for the Editor to pay his respects to the birth of the United States of America.

While sitting in our air-conditioned offices surrounded by our mechanical assistants and electrical gadgets (excuse me for a minute while I turn on the pencil sharpener), it might be appropriate and useful to reflect for a moment on the true state of medicine as a profession then and now. What have we gained? A great deal, obviously. Indeed, one of those who wrestled most manfully during the a-borning of our country might have lived a number of years longer had penicillin, skilled surgery, and aspirin—rather than purging and bleeding—been available for the treatment of quinsy.

The list of medical miracles of the past 200 years is long and impressive. Much physical suffering can now be alleviated. Some ills can even be cured. Mortality rates for all ages are dramatically lower. But medicine is an art as well as a science. Our patients are persons, not cases. For many individuals, quality of life may

be fully as important as quantity. Are there any losses in the quality of life of our patients, particularly in those areas in which we, as physicians, can make contributions. There may well not be any such losses, but the art of medicine needs the same critical thought and care that is given to the science of medicine.

Short of science fiction there is no way to turn the clock back. Even the most nostalgic of us would not really want to go back to the so-called "good old days." The present is all we really have to live in—that and our hoped-for future.

So, as we begin our Third Century as Americans, we shall press on with optimism and determination, resolved to hold onto the best of the old as we incorporate the best of the new into our lives and into our services to our fellow man and to our Country.

Happy birthday to all of us, for we are America.

W.T.T.



The colonial Capitol at Williamsburg still flies the Union Jack, but only symbolically, for within these walls George Washington, Thomas Jefferson, Patrick Henry and other patriots helped lead the American colonies to independence and their own flag.

Medicine and the Legislature . . . .

The President Speaks to Virginia's Congressmen

As a rite of spring, principals of The Medical Society of Virginia go to Washington for a meeting with Virginia's ten congressmen and two senators. Attending this May were Dr. Raymond S. Brown, president, and Dr. W. Leonard Weyl, president-elect; Robert I. Howard, James L. Moore, Jr., and Willard C. Osburn, MSV staff; and Robert G. Stuart, VaMPAC staff. They lunched with the legislators in the dining room of the Speaker of the House of Representatives. Afterwards Dr. Brown gave the speech here reprinted from the Congressional Record.

THE Medical Society of Virginia appreciates this opportunity to get together and break bread with our friends in Congress. Our Congress is the world's greatest deliberative body. You remember the story about the preacher who turned from lofty pious sentiments to damning individual sins, and heard one of his parishioners mutter, "He's stopped preaching and started meddling." I think Congress sometimes stops deliberating and starts meddling.

It has been traditional through the years, when coming to these meetings, that we have some theme to bring before you. Today there are so many themes and so many problems that I am just going to make a few comments and tell you my druthers.

The appetite for medical care is insatiable. The budget for socialized medicine in Canada is already 50% of the total tax revenue in some provinces. Since the US in USA now stands for unlimited spending, you can see what will happen here.

All societies seem to tend more toward socialism because each small step toward socialism seems so necessary and good at the time. We just can't believe the lessons of history that the final result of socialism is always financial and moral bankruptcy, followed by totalitarianism. Pragmatically, I think it unlikely that we can do anything to reverse the trend, except fight a delaying battle. The cause is lost in any nation when more than 50% of its electorate is voting for someone else's money, and we passed that point many years ago.

We now have the mandated HSA's, PSRO's, and the other groundwork for socialized medicine. I can understand why you think these controls may be necessary now, because the only control that has ever effectively managed the affairs of humans—namely, the market economy—has been effectively bypassed by first-dollar insurance coverage, Medicare, and Medicaid. Unless and until deductibles and coinsurance are made mandatory, there can be no stopping the ever-escalating cost of medical care.

We must go back to having insurance as insurance and not as a method of budgeting for expected future expenses.

Our voluntary organizational heart-lung-cancer-et cetera have been and still are potent forces for improvement and innovation in medical areas. However, it appears that the rising of taxation will erode the revenue sources

"Please help reduce the ever-entangling bureaucracy that threatens to smother all initiative."

of all of these volunteer organizations. This leads to more cries for government action, more taxes, and less services. Since it will be easier to reduce the fees of physicians than control the medical wants of the public, the physicians' work load will go up and their incomes will come down. Since bureaucrats don't like to see anyone else doing paperwork, the private third-party payers will gradually be gobbled up by big government. Even though recent research indicates that the processing of an insurance claim by private insurance companies is $3.50, it is $11.00 by government workers.

Since hospitals are expensive and susceptible to cost controls, proliferating utilization regulations and diminishing certificates of need can be expected.

These increasing costs and proliferating control plans are a necessary part of the governmental process for controlling its expenditures. The cost of managing and controlling a program such as Medicaid is understandable and may well be accepted by society. The fact lost sight of is that whatever is free is abused. If our resources were truly infinite, controls would not be necessary, but we live in a finite world. A situation in which there are no restraints on the use of medical care leads to a situation where all of the resources of the country may eventually have to be spent for health care to the detriment of other sectors of our economy and society. Virginians have, and will, accept with grace the law of the land, but we would like to see again the law favor the industrious and productive citizen rather than the drone. We hope that Congress will do what it can to return America to the era of responsibility for self and family.

The more complicated life gets, the more important it becomes that each person be allowed to run his own life and the less likely it is that a rules-bound bureaucracy will be able to effectively rule our lives.

Please help reduce the ever-entangling bureaucracy that threatens to smother all initiative.

Raymond S. Brown, M.D., *President*
The Medical Society of Virginia

Senator, You Are On the Right Track

Quote of the Day: Republican Senator Jesse Helms of North Carolina, addressing the South Carolina Medical Society: "I know how dispiriting it must be for all of you [doctors], bombarded almost daily by those dreadful schemes with their assorted initials—HMOs, PSROs, MAC. . . . I'm often tempted to introduce a program of my own called KABOOM—Keep All Bureaucrats Out of Medicine."—From the Richmond *News-Leader*, March 22, 1976.

Renal Abcess: Old Problem with a New Look

ELWOOD B. BOONE, JR., M.D.
M. J. V. SMITH, M.D.
Richmond, Virginia

A review of 18 patients seen over seven years suggests that the presentation and genesis of renal abscess has changed. It would appear now to be a disease associated with debility, lowered host resistance, and gram negative organisms.

A RECENT review points out that perinephric and renal abscesses are a rare occurrence, particularly since the addition to our armamentarium of powerful antibiotics.[1] Almost invariably a discussion of this problem starts with a discussion of the role of staphlococcus in the genesis of this disease process.

However, a review of our clinical experience with this disease suggests that perinephric and renal abscesses are not rare. It is true that the clinical picture has changed, but it is the advances of medical treatment, predicted to eradicate the disease, that are masking the problem. Unless the clinician has a high index of suspicion, the diagnosis will not be made, which will result in continuing morbidity and mortality.

Several recent reports have stressed the importance of the angiographic diagnosis in the management of patients.[2,3] It seems worthwhile to review our experience of renal abscess over the past seven years, so that we may show how the clinical picture has changed. In particular it is desirable to highlight the diagnostic clues, so that the institution of early therapy will prevent the almost inevitable enlargement of the abscess, going on to formation of perinephric extensions. This disease has an extremely high morbidity and mortality. It is our experience that perinephric abscess is three times more common. Yet it has a similar clinical presentation; it is only the time factor that is different.

From the Division of Urology, Medical College of Virginia, Richmond.

Presented in part at the annual meeting of the Mid-Atlantic Section, American Urological Association, Hot Springs, Virginia, October 23-26, 1974.

Submitted 9-19-75.

Patient Presentation and Findings

Eighteen patients with renal abscesses were seen at the Medical College of Virginia from 1967 through 1974. The age range of the patients was from 4½ to 83 years, with the majority appearing in the fourth and fifth decades of life. There were 13 females and five males. The race distribution was equal with nine blacks and nine whites. Also, there was an equal distribution of the side of involvement.

The most common presenting signs and symptoms were fever (10), and abdominal and flank pain and tenderness (10). A mass was palpable in five patients, and associated lower urinary tract symptoms were seen in five patients. Four patients presented with anemia, while three had weight loss and weakness. No patient gave a clear history of a skin or respiratory infection. However, the one patient that grew staphlococcus aureus in her urine was found to have multiple facial furuncles and dental abscesses one year following incision and drainage of her left renal abscess.

Several patients had predisposing conditions which may have made them more susceptible to abscess formation. Three patients were diabetics, one had sarcoidosis, another had a vasculitis for which she was being treated with

prednisone. Two patients were chronic alcoholics generally debilitated from cirrhosis, and another was a quadraplegic with a long history of chronic pyelonephritis and renal stones.

Aids in diagnosis of renal abscess were the pyelogram as a screening device and the retrograde pyelogram, the renal scan, and the renal arteriogram to further define the mass lesions. All 18 patients had abnormal pyelograms with 11 patients demonstrating mass lesions with deformity of the calyceal system. Four kidneys showed delayed function, and four demonstrated renal calculi. Renal scans were done on five patients, four of which demonstrated mass lesions; one showed a nonfunctioning kidney. Renal arteriogram were done on eight patients. All but one revealed an avascular mass. One mass could not be differentiated from a hypernephroma in a 24-year-old medical student; consequently, a radical nephrectomy was performed.

The offending organism was usually a coliform member. The preoperative urine cultures were often negative. The abscesses grew predominantly E. coli and proteus. One urine

TABLE I

	Urine Culture	Abscess Cultures
No growth	7	2
E. Coli	4	5
Klebsiella	3	2
Proteus	0	5
Pseudomonas	2	2
Staph aureus	1	0
Alpha strep	0	1
Cultures lost	1	1
	18	18

was positive for staphylococcus aureus but this organism could not be recovered from the abscess cavity.

In our series, treatment consisted of incision and drainage of the abscess in nine patients. This included all five cases that had been seen in the previous year. A heminephrectomy was performed in one patient. Seven patients had

TABLE II

I & D	9*	(Avg age 36)
Heminephrectomy	1	
Simple nephrectomy	7	(Avg age 59)
Radical nephrectomy	1	

*One nephrectomy following I & D

simple nephrectomies, and one had a radical nephrectomy. The nephrectomies were performed either because of a nonfunctioning kidney or because the mass could not be differentiated from tumor at the time of surgery.

Discussion

Before the era of modern antibiotics, 80% of renal and perirenal abscesses were caused by hemolytic staphylococcus; most frequently there would be a history of a primary lesion on the skin, throat, or lungs from one to eight weeks previously. It was a disease predominately of young people, which ran a severe febrile course associated with leucocytosis and slight anemia. There was often remarkably little in the way of urinary symptoms or findings. It is truly surprising that the changing mode of presentation has not been readily appreciated. In our experience staphylococcus is no longer a major etiologic factor in renal abscesses. Thus the advice of Shearer that this entity should be treated with penicillin and observed is perhaps open to question in this present day.

On two occasions we tried to manage patients conservatively. In neither was there any alleviation of their symptoms. This approach is certainly hampered by the diverse bacteria involved, and in our experience only 40% of patients will have urinary cultures that correspond to the bacteria found in the abscess. This seems to be particularly true of the proteus group, which was an important etiologic agent in our experience.

This report illustrates very clearly that renal abscess is now a disease process associated with debility, lowered host resistance, and gram negative organisms. It is usually a disease with a relatively short history and a marked leukocytosis.

Radiographic and angiographic study, while sometimes helpful, may not allow one to make a firm exclusion of a necrotic avascular renal carcinoma. A helpful finding that is not often mentioned is that there is usually limited movement of the kidney in the patient with renal abscess. The reason for this becomes readily apparent at surgical exploration, when there is invariably considerable perinephric reaction. Such reaction if neoplastic is normally associated with the obvious angiographic changes of spread beyond the capsule. If in spite of these clinical findings the operator is unable to make a firm decision, then nephrectomy is clearly indicated as illustrated by one of our reported patients.

Renal scans are an extremely useful diagnostic procedure in helping to distinguish between an abscess, renal neoplasm, and aberrant columns of Berlin, because the last two will usually show increased uptake while the former will be cold.

All urologists are becoming familiar with the "nonfunctioning" kidney sometimes seen during a severe attack of acute pyelonephritis. Presumably this is caused by acute reactive edema within the kidney substance, as this kidney will appear to "start functioning" following appropriate antimicrobial therapy. One is compelled to wonder whether this may not in fact be the early stage of renal carbuncle formation prior to the existence of a localizing abscess cavity, so that whether an abscess develops or not will depend upon the rapidity with which this reactive edema subsides. Certainly the so-called hematogenous spread associated with the classical staphylococcal abscess is now rare, and another explanation for the genesis of this condition must be sought.

The clinical course of a renal abscess can be described as follows.

- Development of multiple abscesses with total destruction of the kidney,
- Drainage of the abscess cavity into the collecting system,
- Extension of the process into the surrounding tissue to form a perinephric abscess,
- Arrest of the process forming a sterile abscess.

Clearly each one of these is an undesirable late complication with high morbidity and mortality. Early recognition by the suspicious clinician and treatment by incision, saucerisation of the cavity and drainage are the most successful methods. It is amazing how rapidly the patient will recover and how little obvious evidence of this disease will be apparent in the postoperative period.

Summary

Renal abscess is an old problem with a new look. A review of 18 patients seen over seven years at the Medical College of Virginia suggests that the presentation and genesis of this condition has changed. It would now appear to be a disease associated with debility, lowered host resistance, and gram negative organisms. The clinician must have a high index of suspicion as his primary diagnostic aid. We feel that early recognition of a renal abscess is mandatory to prevent perinephric extension and ultimate loss of the involved kidney.

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Laboratory Medicine . . . .

The Significance of Cyclic AMP in Clinical Medicine

Mario R. Escobar, Ph.D.
Richmond, Virginia
Beverly A. Weeks, Ph.D.
Norfolk, Virginia

CLINICAL medicine is being influenced in an ever-increasing manner by the role which adenosine 3',5'-monophosphate (cyclic AMP) plays in human body function at the biochemical level. Its seemingly ubiquitous presence in living tissue suggests that cyclic AMP may be useful as a measure of normal versus abnormal function. It is currently the focus of extensive research regarding diagnostic and therapeutic applications.

The concept of cyclic AMP as a "second messenger" of nonsteroid hormone action[1] is based on the ability of the various hormones to act upon their target tissues or cells by coupling to a membrane-bound adenyl cyclase molecule specific for that hormone. This results in the intracellular production of cyclic AMP to activate specific protein in kinases which, depending on their relative concentration in the particular target cell, synthesize some cellular product. Once this ultimate action has been elicited by the hormone involved, cyclic AMP is converted to 5'-AMP by its deactivating enzyme, phosphodiesterase.

The ubiquitous nature of cyclic AMP has been demonstrated by its presence in every tissue type so far tested. Steiner and his associates[2] perfected a radioimmunoassay procedure to detect and measure cyclic AMP in liver, kidney cortex, skeletal muscle, isolated fat cells, heart, pituitary, and small intestines in the range of 100-1000 picomoles/gram of tissue, net weight. They also measured cyclic AMP levels in lymphocytes (3.1 picomoles/10^7 cells), plasma (8-20 picomoles/ml), and urine (4.41 micromoles/24 hours). They found that the cyclic AMP levels could be accurately measured without first having to purify urine samples by chromatography. This information greatly increases the feasibility of measuring urinary cyclic AMP levels on a clinical screening basis. Stefanovich and Wells[3] reported that whole saliva (e.g., from all glands) contains approximately 20 times the normal urinary cyclic AMP concentration, which was also much higher than the level found in normal plasma. The latter indicates local production of cyclic AMP rather than transudation, and then secretion by the gland.

While cyclic AMP is considered ubiquitous in living tissues, its measurement for clinical purposes is, for obvious technical and economic reasons, generally limited to readily available body fluids, i.e., plasma and urine. Studies showing the usefulness of these measurements in clinical medicine generally were projected along the lines of previous studies using, for example, glucagon[4] or parathyroid[5] hormones. These studies measured the increase of cyclic AMP in plasma and urine induced by the intravenous administration of the respective hormones. Both studies normalized the amounts of cyclic AMP per gram of creatinine to allow for variances in urine osmolarity, since 24-hour creatinine excretion is a relatively constant value in a given individual. Renal clearance studies comparing cyclic AMP clearance from the plasma with that of inulin, the clinical standard, indicate that the increased urinary cyclic AMP seen after hormonal infusion corresponds directly to increased plasma cyclic AMP, rather than representing a local phenomenon of the renal tubular cells.

From the Division of Clinical Pathology, the Medical College of Virginia, Richmond, and the Department of Biological Sciences, Old Dominion University, Norfolk.

The clinical application of cyclic AMP can be accomplished in one of several ways. The hormone in question can be administered to the patient, after which its effectiveness might possibly be monitored by the appearance of cyclic AMP in body fluids, usually urine or plasma. This application can be used both as a diagnostic tool and as an efficacy check on a therapeutic regimen of hormonal replacement. Another way of using the cyclic AMP-adenyl cyclase system for clinical benefit is to administer drugs which have their effect on the enzymes involved in the system, such as an adenyl cyclase enhancing drug or a phosphodiesterase inhibitor, either of which will result in an increase in intracellular cyclic AMP and thus an enhanced hormonal effect. This method has readily apparent therapeutic value, as does the direct administration of cyclic AMP, generally to a localized area due to the activity of phosphodiesterases in nearly all tissues.

OF ALL the actual and potential applications of cyclic AMP, none has been greater than in the diagnosis of parathyroid abnormalities. Schmidt-Gayk and Roher[5] compared urinary cyclic AMP concentration with serum calcium and phosphate levels as well as renal phosphate clearance values in patients with primary hyperparathyroidism. Of the nine patients in this limited study, all of them showed increased urinary cyclic AMP as expected from elevated parathyroid hormone; while only seven exhibited the expected elevation in serum calcium, six showed elevated phosphate clearance, and only five had decreased serum phosphate. When taking into consideration the high numbers of false negative results obtained from other tests, this study demonstrated that the measurement of urinary excretion of cyclic AMP can be a sensitive diagnostic tool in the detection of primary hyperparathyroidism. Conversely, it should be expected that hypoparathyroidism may result in urinary cyclic AMP levels lower than normal, but that these levels would increase up to or above normal with the administration of parathyroid hormone.

The real value of cyclic AMP in this area lies in the differential diagnosis of pseudohypoparathyroidism.[6] In this condition, patients present with the symptoms of hypoparathyroidism. They have low serum calcium levels[4] with higher than normal values of circulating parathyroid hormone, thus indicating end-organ resistance to the latter. As part of the differential diagnosis of this condition, urinary excretion of cyclic AMP is measured as a response to an infusion of purified parathyroid hormone. The end organs in idiopathic or surgical hypoparathyroidism, in this case the renal tubule cells, are still responsive to hormonal stimulation with a resulting increase in the urinary excretion of cyclic AMP. If, however, the patient has pseudohypoparathyroidism, an infusion of parathyroid hormone does not affect the urinary cyclic AMP level because of a metabolic defect in the parathyroid hormone-sensitive adenyl cyclase of kidney and bone.

A refinement of this differential diagnosis to include transient fluctuations of laboratory calcium values, due solely to increased calcium intake, was outlined by Pak and his associates.[7] They suggested that urinary cyclic AMP values should help in the differential diagnosis of what they classify as resorptive, absorptive, and renal hypercalciurias. Resorptive hypercalciuria is equivalent to primary hyperparathyroidism and, as previously stated, will result in a consistently increased urinary excretion of cyclic AMP. Absorptive hypercalciuria is purely a dietary phenomenon seen after a large oral calcium load, in which cyclic AMP levels are basally normal in the urine and rise with the oral calcium load in response to increased circulating parathyroid hormone on a temporary basis. Renal hypercalciuria is the equivalent of pseudohypoparathyroidism, with no change in the urinary excretion of cyclic AMP even after a large oral calcium load.

A complicating factor in the differential diagnosis of these problems can be illustrated by the report of a case[8] showing elevation of parathyroid hormone activity, serum calcium, and urinary excretion of cyclic AMP, all of which

would seem to indicate primary hyperparathyroidism. However, the patient's parathyroids were normal. The presence of a malignant tumor with metastases to the bones pointed out that the tumor was secreting a substance with parathyroid hormone activity.

Patients suffering from psoriasis have been found to exhibit a lower cyclic AMP level in their epidermal lesions.[9] This condition reflects a failure of the normal process whereby B-adrenergic antagonists inhibit epidermal mitoses, via cyclic AMP. Possible therapeutic value on the basis of methylxanthine inhibition of phosphodiesterase activity has been suggested[10] since injections of aminophylline or theopylline resulted in a rapid rise in cyclic AMP in the adrenal cortex, adrenal medulla, liver, and kidney of rats. In all instances, a four- to 20-fold increase in ornithine decarboxylase activity was noted. This enzyme is involved in the polyamine biosynthetic pathways leading to stimulation of tissue hypertrophy, cell mitoses, and normal cell differentiation, all of which suggest a curative effect of methylxanthines upon psoriasis and related conditions.

Cyclic AMP has also been implicated in the inhibition of platelet aggregation through the mediation of Prostaglandin (PG)E_1.[12] Platelets exhibit an increased aggregation in the presence of ADP, PGE_2, serotonin, or thrombin, all of which lead to a decrease in cyclic AMP within the platelets. PGE_1, however, led to an increase in intra-platelet cyclic AMP and in inhibition of platelet aggregation. Theophylline and PGE_1 act synergistically in the inhibition of platelet aggregation.[13] The former inhibits platelet phosphodiesterase. This suggests the possible therapeutic use of PGE_1 and/or theophylline in patients at risk from thromboembolic phenomena.

Methylxanthines have been shown to inhibit the release of histamine from human leukocytes by increasing the intracellular levels of cyclic AMP.[14] Cyclic AMP is thus postulated to play a role in the regulation of allergic histamine release. Smith and Parker[15] noted lower than normal cyclic AMP levels in leukocytes of patients with allergic asthma. These levels were corrected with the administration of norepinephrine and isoproterenol.

Cyclic AMP has also been used clinically in the differential diagnosis of affective disorders. Paul et al[16] studied a group of psychiatric patients who were kept free of drugs or foods affecting indole or catecholamine excretion for two weeks. They noted that the urinary excretion of cyclic AMP in psychotic depressive individuals was significantly lower than normal, whereas it was normal or slightly elevated in psychoneurotic depressive patients. Manic depressive patients exhibited a marked increase in their excretion of urinary cyclic AMP while in the manic state. The varying urinary excretion levels of cyclic AMP correspond to those in the brain, and are thought to be functionally related to the action of catecholamines and serotonin, both of which are implicated in the biogenic amine theory of depression.[17] Treatment of these patients has been successfully carried out with lithium carbonate by controlling the urinary excretion of cyclic AMP.

Cancer therapy represents another area where cyclic AMP is proving to be of definite value in clinical medicine. Control over mitosis has been demonstrated to be a property of the presence of cyclic AMP, with increasing levels leading to inhibition of cell proliferation.[19] This concept has been put to use in an effort to halt the rapid growth of malignant tumors. Seller and Benson[20] found that Ehrlich ascites tumor cells exhibited a diminished adenyl cyclase activity leading to deficient production of cyclic AMP and, therefore, uninhibited cell growth. They were able to demonstrate decreased tumor growth in terms of fewer total as well as fewer atypical cells among those left by treatment of mice with cyclic AMP and theophylline *in vivo*. Cho-Chung and his coworkers[21] were able to examine *in vivo* several kinds of tumors with regard to their response to treatment with cyclic AMP. They found positive results with estrogen-dependent mammary tumors and Walker 256 carcinomas. Although this area of endeavor is relatively new, perhaps it will be the most beneficial to man.

(*References on request.*)

Flu Sunday for the Elderly

JOHN ALEXANDER, M.D.
Lovingston, Virginia

The recent appearance of swine influenza virus, thought to be similar to the cause of the disastrous epidemic of 1918-19, has prompted plans for a national immunization effort. The following article raises an important question about the possible success of such a program, especially since there is no conclusive evidence that swine flu actually will cause a significant problem. Also, because of the need for mass production of vaccine, purification methods may be less than optimal, and the resulting large number of adverse reactions could significantly affect participation..

INFLUENZA is a serious disease for those over 60 years of age and anyone with a chronic disease. For many years, the Center for Disease Control has recommended that people in the high risk groups be immunized. The best estimate is that 10-20% of the high risk population receive influenza protection each year.

The Thomas Jefferson District Health Department, Albemarle County Medical Society, and the Jefferson Area Board for Aging recently joined together to try to increase the protection of elderly residents in the area. On a Sunday afternoon in October, 1975, flu shots were administered to 1,146 persons, all of them past middle age and living in Charlottesville and the surrounding counties. Over 200 volunteers and numerous organizations participated.

Areas served by the immunization locations were Albemarle, Fluvanna, Louisa, Nelson, and Greene Counties, and Charlottesville. Participation was much the same in each of these areas, the average being 7% of the 60-years-and-over population.

Publicity was begun about three weeks before and consisted of TV and radio announcements, newspaper articles, leaflets in shopping bags, and church announcements. When participants were asked their source of information about the program, 74% said they had read about it in the newspaper. The next best source was a friend, which accounted for about 10%.

Transportation was made available in all areas but was used by only a dozen people. There was a charge of one dollar for each vaccination.

Participants were asked about previous influenza immunizations, and only 37% had been immunized during the previous year, suggesting that at least two-thirds of those immunized would not have received influenza protection without the program.

Results

A sample was selected to determine adverse reactions to the flu vaccine (Bivalent Influenza Vaccine, Merrell 75-76, Lot #1157 EK). From the list of 1,146 persons immunized, 117 names were selected at random, and followup information was obtained by phone, mail, or home visit on 115 of these.

Systemic reactions did not seem particularly common or severe, as can be seen in Table I.

Table I

Systemic Reactions

	None	Mild	Moderate	Severe
Headache	85%	7.8%	2.6%	4.3%
Chills	93%	2.6%	1.7%	2.6%
Muscle Ache	90%	5.2%	4.3%	0
Weakness	93%	4.3%	2.6%	0
Nausea	98%	1.7%	0	0

Fever was noted by 6% of the patients, but only one had a temperature above 101°F.

Redness was the most common local reaction, and only one patient described severe

From the Nelson County Health Department, Lovingston.

Submitted 2-26-76.

pain. The local reaction rates are shown in Table II.

Reaction rates were also analyzed by age. Generally, as age increased the percentage of

Table II

Local Reactions

	None	Mild	Moderate	Severe
Pain	87%	8.7%	3.5%	.87%
Redness	84%	12.2%	2.6%	.87%
Swelling	90%	7.8%	1.7%	0

persons with reactions decreased. For example, only 46% of those aged 60 to 64 described no reaction, compared with 75% in the age group 80 and over. The progressive

Table III

Reactions by Age

Age	Number	Only Local Reaction	Systemic Reaction
60	7	1	1
60-64	28	7	8
65-69	34	7	6
70-79	29	1	8
80 & Over	16	1	3
Total	114	17 (15%)	26 (23%)

decrease of reaction rate by age was, however, not statistically significant when the chi-square test was employed. Table III shows the reaction rates by age.

The majority of the reactions lasted between 12 and 24 hours. Three persons noticed weakness and muscle aches lasting over 48 hours. No significant differences in reactions could be found when sex and racial characteristics were analyzed.

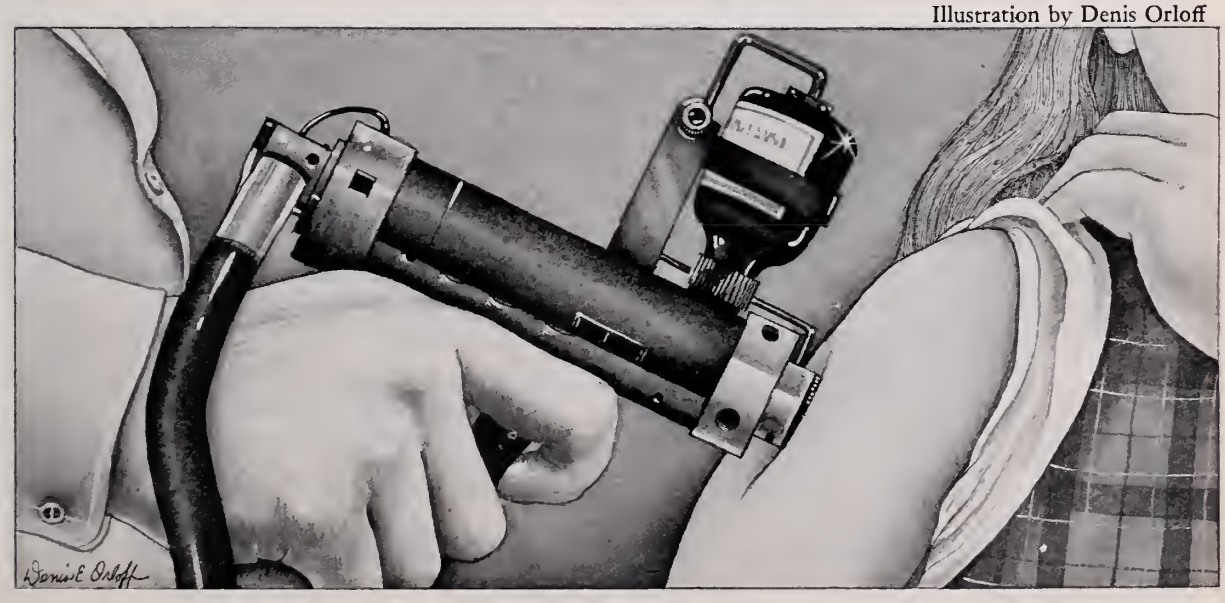
Conclusion

A great deal of effort produced a relatively small result: 7% of the elderly population in the Charlottesville area were protected against influenza. About one-third of these had been immunized in the previous year and would likely have received the vaccine from another source.

It is our estimate that in a campaign of this type, utilizing existing community resources, no more than 15% of the elderly population will participate. This may be due to fear of injection, a belief that the vaccine is worse than the disease, or lack of motivation to protect one's health. Considering the variability of the virus, marked difference in yearly prevalence, the need for yearly booster, and such poor participation, mass influenza campaigns would not seem to produce significant benefits. A yearly informational campaign and perhaps a few community centers offering low cost vaccine might well be sufficient, considering other priorities.

For reprints: Doctor Alexander
Nelson County Health Department
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1. Santiago PJ, Santini R Jr, Perez E, et al: Congenital isolated defect of folic acid absorption. J Pediatr 82:450-455, 1973
2. Hunter D: The Diseases of Occupations, Vol. III. London, English Universities Press, 1969
3. Nyhan WL: Nonketotic hyperglycinemia. Heritable Disorders of Amino Acid Metabolism, edited by WL Nyhan. New York, John Wiley and Sons, 1974, pp 309-323
4. Jones JJ, Smith AW: Thyroiditis in the adolescent. Presented at the 49th annual meeting of the Endocrine Society, Chicago, June 20-22, 1967

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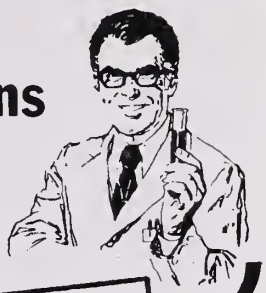
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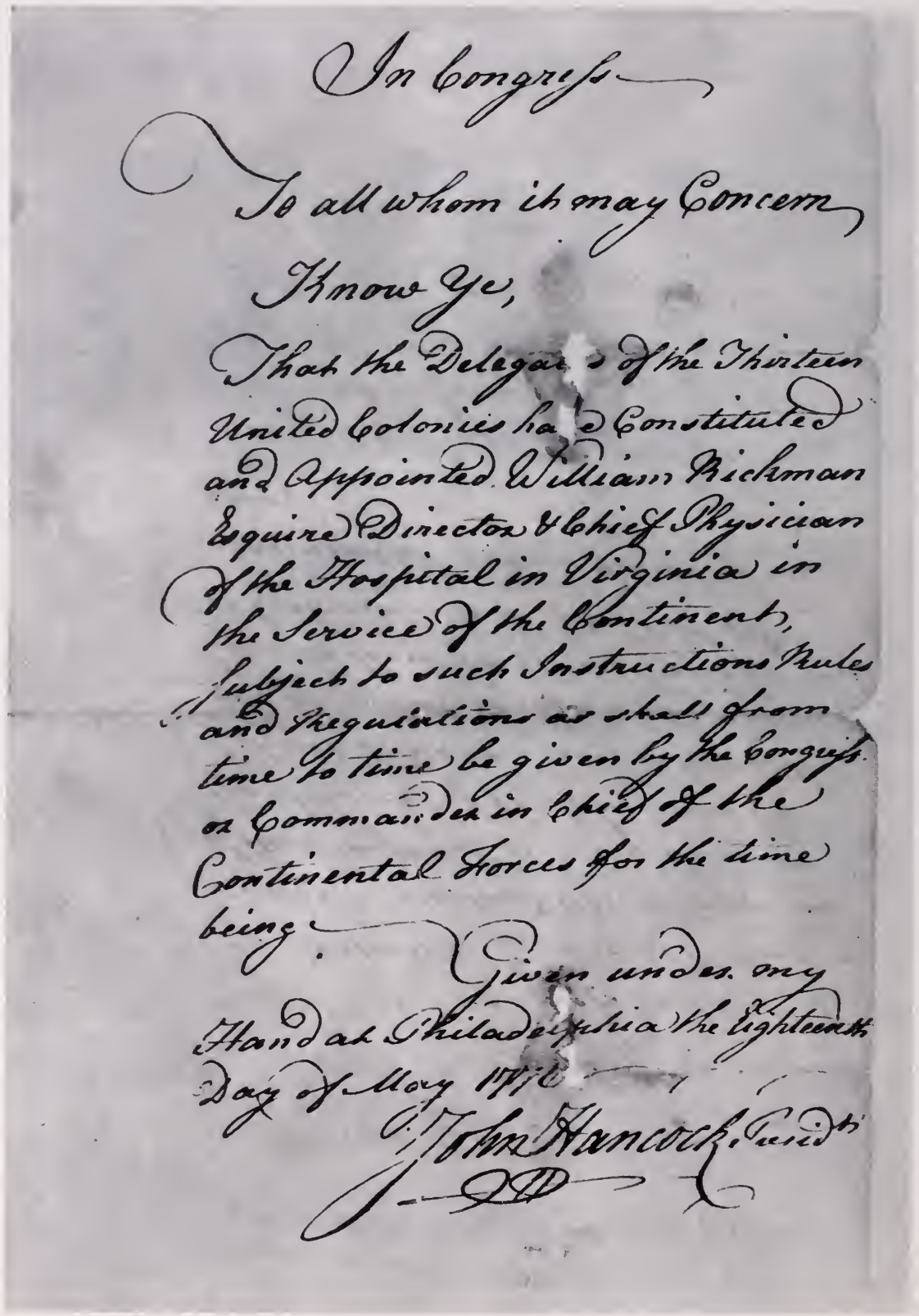
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Given under our Hand at Philadelphia the Eighteenth Day of May 1776

John Hancock. Presidt

Signed with the flourish of John Hancock's familiar signature, this is the document appointing Doctor William Rickman as "Director and Chief Physician of the Hospital in Virginia." Courtesy of the Virginia State Library.

Doctor Rickman and Virginia's Continental Surgeons

HARRY J. WARTHEN, M.D.
Richmond, Virginia

ON January 1, 1766, a warrant was issued appointing William Rickman surgeon to H.M.S. Launceston, which sailed shortly thereafter from Sheerness, England, to North America, where it cruised along the Atlantic Coast from Halifax, N.S., to the Virginia Capes.[1] Several years later on October 16, 1769, the British Admiralty received the following message:

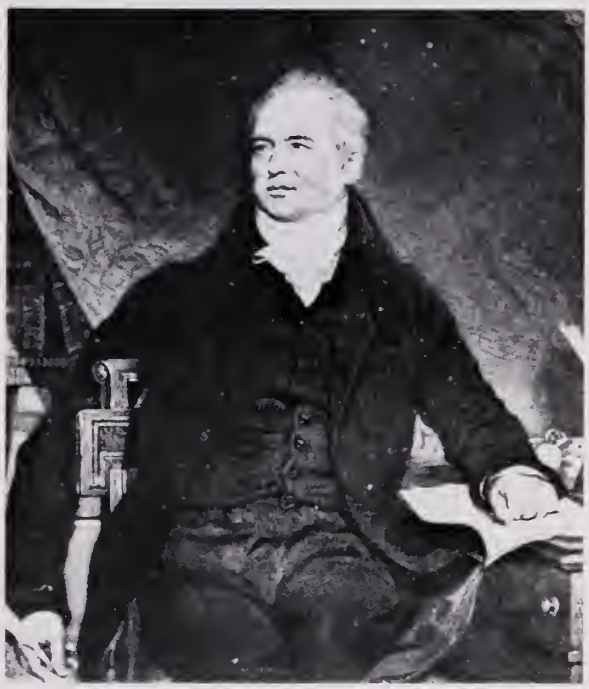
Sir,

Captain Gell, Commander of His Majesty's Ship Launceston, having reg. to me that Mr. William Rickman, the surgeon, is in so bad a state of health as to be unable to do his duty whenever the ship is at sea (having) enclosed me a letter wherein he desires to be superceded, I granted his request which I hope their Lordships will approve (of). I have moved the surgeon on the Beaver into the Launceston and appointed Mr. William Miller in his room.

I herewith send you a copy of Captain Gell's letter as . . . Mr. Rickman's to him. I am, Sir

Your most obedient
Humble servant
Samuel Hood[2]

Surgeon Rickman's name does not appear on the Royal Navy's roster after August, 1769, but we soon find a Dr. William Rickman engaged in the active practice of medicine in Charles City County. There is every reason to believe he and the naval surgeon were one and the same.[3] His career in Virginia may be followed readily through the courtesy of his great-great-great-grandson, William V. Rickman of Danville, and Mr. Rickman's sister, Mrs. Paul L. Dent of Louisville, Kentucky, who have spent many years gathering information about their distinguished ancestor and have shared this information with the writer. The present-day Rickmans descend from the doctor's first wife, whom he married in England.



Descendants of Dr. William Rickman believe this to be a portrait of him. The artist is unknown. Courtesy of Mrs. Paul L. Dent.

Dr. Rickman purchased "Kittiewan", a well known plantation situated on a creek by the same name in Charles City and originally owned by Governor Sir George Yeardley. The manor house, according to the late Dr. Lyon G. Tyler, was built in the first quarter of the eighteenth century.[4] It is unusual in a large, but relative simple, 1½-story farm house to find its great room completely paneled from floor to ceiling. The present owners, Mr. and





Two views of the manor house of Kittiewan, the Virginia plantation owned by Doctor William Rickman. It is an L-shaped dwelling, larger than these views indicate, with handsome chimneys and eleven dormers. The porch is referred to as Queen Anne style; the horizontal latticing is a modern addition.

Mrs. William E. Cropper, have carefully preserved the house and continue to maintain the land as an operating farm.

Dr. Rickman found time to serve as one of His Majesty's justices of the peace[5]; but, as time went on, his allegiance to King George III lessened, for the *Virginia Gazette* reported the doctor's participation in a meeting in Williamsburg on December 17, 1774, called for the purpose of "preserving the liberties of America." [6] Benjamin Harrison of Berkeley was also present at the meeting and was chosen chairman. Shortly afterward, the *Virginia Gazette* recorded the marriage of the doctor and Miss Betsey, Benjamin Harrison's youngest sister.[7] Before long Harrison was in Philadelphia with the Second Continental Congress, where he became a signer of the Declaration of Independence. Meanwhile, the Congress issued the following:

In Congress—
To all whom it may Concern
Know ye,

That the Delegates of the Thirteen United Colonies have Constituted and Appointed William Rickman Esquire, Director and Chief Physician of the Hospital in Virginia in the Service of the Continent, subject to such Instructions Rules and Regulations as shall from time to time be given by the Congress or Commander in Chief of the Continental Forces for the time being. Given under my hand at Philadelphia, the Eighteenth Day of May, 1776

John Hancock, Presidt.[8]

The appointment of an English surgeon to the senior medical post in Virginia occasioned unhappiness on the part of some Virginia physicians, especially in the case of Dr. James McClurg of Williamsburg. In April, this Edinburgh-trained physician had written his former William and Mary College friend, Thomas Jefferson, requesting the directorship of hospitals in Virginia.[9] Perhaps the request arrived too late, but McClurg swallowed his pride and, during the next four years, served as a military surgeon in eastern Virginia with one brief interval as professor of anatomy and medicine at William and Mary College.

The designation of Dr. Rickman to this high office appeared a month later in the Williamsburg paper, which also noted the promotion of Colonel Hugh Mercer to the rank of brigadier-general.[10] General Mercer was a Scottish physician, who practiced and kept an apothecary shop in Fredericksburg, and was one of only twelve general officers from Virginia who served in the Continental Line. He died of battle wounds in Nassau Hall after the Battle of Princeton.

Meanwhile, Dr. Rickman undertook his new assignment with enthusiasm. He requested that all who had old linen suitable for the preparation of lint or bandages forward it to his newly established office in the Masonic Hall in Williamsburg.[11] An equally pressing need was the establishing of a military hospital. A request for bids was published over his name in October, 1776, for a hospital to be established near Williamsburg.[12] The urgent need for hospital beds prompted Dr. Rickman to visit the College, the Governor's Palace, and other nearby dwellings in an effort to find temporary quarters.

The Wren Building was found to have "room enough for the purpose of an Hospital, yet by reason of the many partitions therein, it will not admit of that thorough passage of Air so absolutely necessary for invalids. And your Committee beg leave to represent that the College has at very considerable expense been lately repaired, whitewashed and thoroughly cleaned for the reception of Scholars, who are expected to return to their Studies on Monday next at which time the vacation ceases, that there are a large and valuable Library and Apparatus in it which might probably be damaged in the removal, perhaps totally ruined." [13]

Another unexpected obstacle was "that several young gentlemen of the country have been accustomed to receive maintenance and education there as Scholars on certain Foundations established by different Benefactors." It also appears "from examination of the Palace and the Opinion of Doctor Rickman that it is adapted in all respects, without any alternations of Consequence for an Hospital; whether considered as to size, situation, plan or necessary offices; that add to this, there stands a publick Building in the center of the Park, which may be taken as an appendage to the Hospital, whither persons labouring under epidemical or infectious Disorders may be removed, and the Disease thereby prevented from spreading." [13]

The necessary legislation was adopted in order to transform the Palace into a hospital, but two weeks later the decision was reversed and the Palace continued to be the residence of the Governors of Virginia until the capitol was moved to Richmond in April, 1780.[14] Not until the Continental Army entered Virginia in preparation for the siege at Yorktown was the Palace used for medical purposes. Meanwhile, a building was erected prior to 1779 a few miles east of Williamsburg on the York Road and named the Vineyard Hospital.[15] No doubt this was the hospital for which bids were requested in 1776.[12]

Dr. Rickman's absence from Kittiewan brought about added personal problems, for a notice appeared in the *Virginia Gazette* warning: "All persons are hereby forewarned from hunting, fishing or fowling on the lands of the subscribers in Charles City, without leave first obtained. David Minge, William Rickman." [16]

The Commonwealth of Virginia was spared major military invasions until the final year of the war, and Dr. Rickman was relatively free from inter-departmental squabbles or the intense rivalry that marred the Continental Medical Department north of the Potomac. It cannot be said he escaped entirely, for there were complaints by the line officers of the North Carolina and Virginia militia concerning fatalities following smallpox innoculations in Alexandria. Dr. Rickman was suspended briefly in December, 1777, pending an investigation by a medical committee which subsequently acquitted him of all charges.[17]

Late in the war, General Horatio Gates, while passing through Virginia, took Dr. Rickman to task for some imagined oversight. The good doctor's temperate reply, which is quoted at length, epitomizes the overlapping authority, the paucity of supplies and the general confusion that existed throughout the American Revolution.

Charles City County, Virginia
ye 2d August, 1780.

Sir:

I was yesterday favoured with Your Letter of the 19th ultimo, wherein you inform Me that on Your Arrival at Hill you found an Hospital under the Director of a Regimental Surgeon with-

out Medicines or Stores and that no Hospital Establishment is with the Army, and that the Sick are badly accommodated. In Answer thereto, permit Me to assure You, Sir, that I have never been applyed to on the Subject before till about ten Days since I received a letter from Major General The Baron de Kalb, directing Me to send a Surgeon to take charge of the Hospital with, proper Stores, &c. I . . . wrote Him that I shall comply with His Orders as far as lay in my part by directing a Surgeon to that Post with Medicines that it was impossible for Me to send Stores not having any or money to purchase them.

Had I know when You passed through this State I should have waited on you either at Richmond, or Petersburg to have acquainted You with the State of the Hospital Department, but I did not hear of Your being in Virginia till after You left the last mentioned Town.

In obedience to Your orders I should immediately repair to Your head Quarters but by the terms of the Appointment which I received from Congress a copy of which I herewith enclose My Department goes no farther than Virginia; added to this I asked the President of Congress in April last to resign the Office but hitherto I am without His answer and know not if I am Still to consider Myself in the Service or out of it.

I shall immediately communicate Your Orders to the Apothecary and the Gentlemen belonging to the Hospital and direct Medicines to be forwarded to Your headquarters from Petersburg or Chesterfield, to which places they are all sent by order of Brigadier General Muhlenburg, and which I shall go to-morrow for that purpose.

I . . . wrote repeatedly to the Director General the necessity there was of sending money for the use of the Hospital and that without it I could not procure the necessary articles for the use of the Sick, but never received any answer, and since I heard from Doctor Brown that He officiated in the Director General's place, I have likewise wrote him on the same subject, but am as yet without his answer. I have been several months without Money either to pay the Officers or purchase the necessary stores some time before they were removed from Petersburg to Chesterfield I bought on My own Credit.

I have the honour to be, with great respect, Sir,
Your Most Obedient & very humble Servant,
William Rickman[18]

The doctor's health deteriorated as the war continued. He first submitted his resignation in April, 1780, but not until October was he released from the Army.[19] A letter from Thomas Jefferson, then Governor of Virginia, to Baron von Steuben, commander of forces in Virginia, dissipates a widely held supposition that Jefferson had urged the appointment of Dr. McClurg, whereas Benjamin Harrison had designated his brother-in-law, Dr. Rickman, for the desired post. On February 21, 1781, Jefferson wrote, in part: ". . . The enclosed letter from the Continental Director of the Hospital at Fredericksburg being proper to be transmitted to *whatever person has succeeded Dr. Rickman* . . . (italics ours) I take the liberty of submitting it to your order. Thomas Jefferson" [20]

Dr. Rickman's successor was Dr. David Gould, about whom we know little, for he served briefly and died on July 12, 1781.[21] Dr. McClurg then, as far as can be determined, at long last received the coveted designation as Director and Chief Physician, and was present in this capacity at Yorktown. Dr. Rickman meanwhile had returned to Kittiewan, where his health continued to fail and he died in the summer of 1783.

Dr. McClurg moved to Richmond shortly after the conclusion of the Revolution and outlived most of his contemporaries by many years. Here he became the first physician to confine his practice to what would now be termed internal medicine. He was one of seven Virginians who served in the Convention of 1787 that drew up our present Constitution. James Madison, who is considered the "Father of the Constitution", noted that Dr. McClurg proposed that the President of the United States should serve "during good behavior." His motion was seconded by Governor Morris but in the confusing terminology of the day, it "passed in the negative." [22] He is now remembered chiefly as the first President of The Medical Society of Virginia. He died in Richmond on July 9, 1823.[23]

Shortly after Dr. Rickman's death, his widow petitioned for his portion of bounty land to which his rank as colonel entitled him. This grant was considerable, for with three years of service (he actually served over four years), he was awarded 6,666⅔ acres, chiefly in what is now Ohio and Indiana. It is pleasant to

)

(August 1st 1780

Ordered that Doct. W. Rickman be informed that pursuant to his former request he is left out in the new arrangement of the Hospital Department.

That the letter be referred to the Board of treasury and that the Board take the proper steps to have his account finally adjusted.

Extract from the minutes
Chas Thomson Secy

366
365
730
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419:00

Doct. W. Rickman

Virginia 4th. October 1780

Hon.ble Sir

3/9

In April last I did My self the honour to write You requesting Leave to Resign the Office of Director of the Hospitals of the United States in this Department never having received Your Answer thereto I am at a Loss to know if I am to consider Myself as continued in the Service or not. permit Me Sir again to solicit the Honourable the Congress for Leave to Resign and as I wrote You in My other Letter I now am and shall at any time when called on be ready to produce proper Vouchers for all Public Money received and paid by Me I have the honour to be with great Respect

Hon.ble Sir

Your Most Obedient & very humble Servant
William Rickman

Dr. William Rickman was notified of his separation from the Continental Army by the letter at upper left, written October 21, 1780. The arithmetic below and to the left of the signature are from Doctor Rickman's hand; he was trying to determine what was owed him by the Congress for his four years of service. Courtesy of the Virginia State Library. The letter at lower right, in Doctor Rickman's hand and with his signature, relates that he had written six months earlier requesting his retirement and was with this letter repeating his inquiry. Courtesy of Mrs. Paul L. Dent.

learn she received a warrant for this bounty in 1784, but Mrs. Rickman remarried shortly thereafter and moved to North Carolina, where she died the following year.[24]

It is hoped that our nation's economy will improve and permit The Medical Society of Virginia to rebuild the brick wall that encloses the graves of Dr. and Mrs. Rickman. The burying ground is badly in need of repair; it would be most appropriate if the Society could restore the final resting place of the English surgeon who served his adopted country so well.

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3. Dent, Mrs. Paul L.: Personal communication. A William Rickman participated in the French and Indian Wars. It is possible Dr. Rickman may have served in the Colonies prior to 1766.
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

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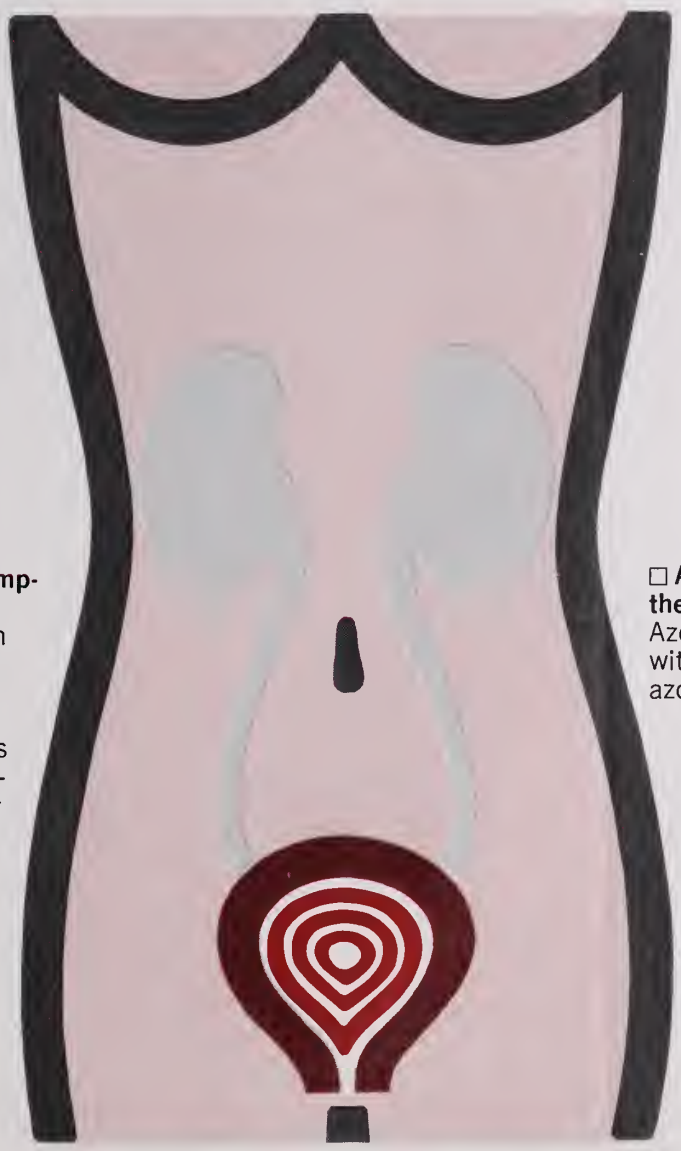
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for the pain

for the pathogens



☐ **Early relief of painful symptoms** such as burning and discomfort associated with urgency and frequency.

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☐ **Appropriate antibacterial therapy:** up to three days with Azo Gantanol, then 11 days with Gantanol® (sulfamethoxazole).

*nonobstructed; due to susceptible organisms

ROCHE

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* **Warning**
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* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. **Accordingly, check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

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Final classification of the less than effective indications requires further investigation.

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The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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Editorial . . . .

From the Iron to the Lace Curtain

MANY of us consider socialized medicine as an entity, with its criteria and bureaucracy of one type. In a recent trip to western Europe of medical leaders of Virginia, our group made visits to five countries. These were Belgium, Sweden, West Germany, Czechoslovakia, and Russia. In each of these countries, we visited medical facilities and talked with doctors, medical planners, and government officials, who described their medical systems. In each of these areas, we had an opportunity to see patients and patient care in the different countries, as well as the method of financing the patient care. My own interest was in psychiatry, and, by prearranged visits with counterparts in these countries, I was able to see more intimately some of the facets that were not evident in group tours.

The impressions that I obtained from my visit to these countries helped me to formulate an opinion of socialized medicine as a spectrum rather than a single entity.

Each of the countries that we visited had a degree of socialized medicine, varying from the Lace Curtain in Belgium to the Iron Curtain in Russia. In Belgium, the National Health Insurance Plan exists, with governmental financing of hospitalizations and, to some extent, outpatient care. The tax system, which carries this weight of medical care, falls very heavily on the wage earner and the employer alike, and pays the doctor. Many doctors are employed by the system and have limitations and fixed incomes. There are some physicians who are permitted private practice; usually these are outside the hospital. We were fortunate enough to visit one of these doctors, who had retired from hospital practice and was doing outpatient work only.

In the Swedish system, the patient's hospitalization is covered except for a minimal stipend paid by the patient; and under this system, a doctor's income is fixed, if he is part of the Plan. He may engage in private practice, but the tax burden is increased heavily for the individuals who engage in private practice. There is little control of inpatient stay in Sweden and much overutilization of hospital beds, with many patients staying beyond expediency. Because of the ease of "sick leave" in Sweden, over 10% of the labor force is out sick at any one time. Under this system, there is one major asset that we do not have, and that is the computerized read-out system, in which each patient has an identification card, so that on admission, pertinent medical data can be obtained within seconds. In Sweden, as in Belgium, there are very few malpractice suits. For instance, since 1964, in a 3,000-bed hospital, there have only been four cases of malpractice claims, and only one claim was deemed valid—the failure to detect a fracture by x-ray. The patient was awarded $4,000 in compensation.

Czechoslovakia has a system set up by the Communists, although the craftiness of the Czechs and their adroitness at beating the system is fantastic. The same type of polyclinic that exists in Russia has been set up in Czechoslovakia, and, in psychiatry particularly, the military and governmental hierarchy receive preferential treatment. The Czechs, in private, make no

claims of liking the system. They disdain it and try various ways of beating the game. In their hospitals, including the general hospitals, the hospital care is actually better than it is in Russia, despite the fact that they are under Russian subjugation. The doctors seem better trained and more interested in the patient, despite the limitations imposed by the occupying Russians. Moonlighting and practicing outside the system exist, despite severe penalty if prosecuted, and somehow the Czechs still survive by their devious methods.

Russia has a number of polyclinics that furnish medical care to a segment of the population, previously assigned by the state, and these outpatient clinics are staffed by 100 to 200 doctors in the Moscow and Leningrad version, and include all fields of medicine except for ob/gyn, pediatrics, contagious illnesses, and mental health. The doctors there carry a fairly heavy load, and something is done for each patient. Salaries are fixed by the state for physicians, beginning at $140 a month (as compared with $180 for a skilled worker), and there is, according to Russian informants, much moonlighting and blackmarketing, particularly in the better-trained category of physicians. There is a great deal of denial of defects in the system, when one meets with a Russian counterpart in a group, but in private, admissions of defects are quite frank and open.

The most impressive thing about all of these countries is the dissatisfaction on the part of the population with the type of socialism that exists in each country. In Sweden, for example, many people go to private practitioners for special care rather than operate within the Plan, although there are economic advantages to receiving care under the Plan. In Sweden, there is also a heavy load on the government for financing the cost of medical care, and according to Swedish officials and American Embassy officials, it appears that the Swedish system is in danger of going bankrupt because of the increasingly heavy costs of medical care. The care of the hypochondriac and people who abuse the system has placed a heavy load on finances. Nursing home care is also increasing in cost; despite large and well-equipped nursing homes, there is still a deficiency of beds. Inflation has hit Sweden, as it has hit the rest of the world, and this has added to the cost of the care. In Belgium, the care seems not to be in as deep financial trouble as it is in Sweden, although the cost to the laborer and the employee is an increasing encumbrance. In West Germany, much the same picture exists. In Czechoslovakia and Russia, we had no means to discern how much of a load was placed on the public; however, defects in the Russian system, which were concealed by the government and medicine (unless one could get private information), showed up in those who sought private care rather than go to the polyclinics or through the socialized system.

The one lesson that stands out, from all of these five examples, is that public dissatisfaction of socialized medicine has increased as the time of its operation has increased. There also is an ever-escalating cost factor, which places a heavy load on the government in financing these systems, and there seems to be no means as yet of controlling the people who abuse the system, or of limiting expenditures.

It is my hope that our American socialized medicine plan will profit, at least, from some of the experience of other countries, and learn from some of the problems that have existed in these systems what safeguards need to

be built in, since our country seems doomed for more socialized medicine in the future.

On arriving in the United States, after being in these various countries, I was overwhelmed by a feeling of sadness that our American system of medicine, which has so effectively made progress in the past, will be limited by increasing socialism and creeping governmental controls.

M. E. Scott, M.D.

P. O. Box 3747
Radford, Virginia 24141

In Celebration of Virginia's Physicians

"Virginia Medicine in the War for Independence," a Bicentennial exhibit depicting Virginia physicians and the practice of medicine in the American Revolution, is on view at the Richmond Academy of Medicine. It is open from 10 to 4 o'clock Monday through Saturday. Admission is free. The Medical Society of Virginia, the Richmond Academy of Medicine and the pharmaceutical firm of A. H. Robins Company sponsored the exhibit, which incorporates a variety of original engravings, drawings, printed panels, documents and Revolutionary-era artifacts. There are primitive surgical instruments, saddlebags used to carry medicine, medicinal herbs such as mandrake and Virginia rattlesnake root, an antique pill-cutting machine, early microscopes and apothecary scales, as well as a valuable collection of 18th century surgical books and a notable group of physicians' silhouettes, including several by Charles Willson Peale and Augustine Edouart. It is expected that the exhibit will also be shown at medical conventions and meetings.

In Search of Clues to Behcet's Syndrome

Dr. Charles L. Cooke hopes Virginia physicians will assist in a study involving the use of transfer factor in the treatment of Behcet's syndrome at the Clinical Research Center of the Medical College of Virginia. Patients are urgently needed. They will receive complete medical evaluations and will be offered the transfer factor treatment; on completion of the study they will be returned to the care of their referring physicians with summaries of findings. To have your patient considered for admission, write or call Dr. Cooke, Division of Immunology and Connective Tissue Diseases, MCV Station, Richmond VA 23298, (804) 770-5193.

A Rorschach Righted

When Dr. John Alexander's nice study of the Albemarle County flu immunization program, "Flu Sunday for the Elderly," was published last month, the illustration with it was so poorly processed by the printer that you may have mistaken it for a Rorschach blot. It was, in fact, a highly professional drawing, and you will find it appropriately reproduced on page 491 of this issue, with editorial apologies.

Letters to the Editor . . . .

To the Editor: Dr. Trent W. Smith's recent letter reprinted in the April issue speaks to a broad application of the term, "plastic surgery." Efforts to define these words have been relatively unsuccessful, for the field recognizes no anatomical, regional, or bodily systems limits. There is, however, a well recognized, universally accepted, and eminently impartial definition of a plastic surgeon: namely, a physician who has met the training requirements of and passed the specialty examination of the American Board of Plastic Surgery.

Those of us in this specialty certainly recognize that there are many over-lapping areas of work with other specialties and that many of the specific or general techniques and philosophies of our discipline apply to other fields of surgery. Because of the long preliminary general training required by the Plastic Surgery Boards, our specialty has traditionally worked closely with most areas of general surgery and the surgical subspecialities. I suppose one may define the principles and philosophies of atraumatic surgical technique and delicate handling of tissues as a "plastic technique"; however, I think most of us would prefer to think of this as good surgical technique in any field of specialization.

The problem raised is not that of poor definition, overlapping fields of interest, or application of techniques from specialty to specialty; the problem is the use by other specialties and other surgeons of an admittedly ill-defined term for no apparent reason other than to capitalize on the general public's association of the words "plastic surgery" with esthetic or cosmetic surgical operations. Your editorial introduction to Dr. Smith's letter noted the pertinence "in this day of specialization and subspecialization and the implications that such may have on assignment of patients, hospital privileges, Board certification, fees and even malpractice suits". This precisely sums up the only explanation for applying the term plastic surgery beyond the definition noted in my opening paragraph. The oral surgeon need not describe himself as an oral plastic surgeon in order to work with facial bone fractures, the otolaryngologist need not define himself as a facial plastic surgeon in order to perform operations within his field of training. The same may be said for all various overlapping fields of surgery. Since each of the varying fields affected wish to practice in only a limited area of the total field covered by the training and examination of the American Board of Plastic Surgery, it would seem no more necessary that they adopt the term plastic surgeon than that the surgeon who applies physiological principles to his work adopt the term physiologist.

George A. Whipple, M.D.

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Fairfax VA 22030

To the Editor: Again this year I am compiling a biting insect summary and would appreciate any case reports of unusual allergic reactions, especially systemic (sneezing, wheezing, urticaria), to bites of insects, i.e., mosquitoes, fleas, gnats, kissing bugs, bedbugs, chiggers, black flies, horseflies, sandflies, deerflies, etc.

I would like physicians to supply me with case reports of those patients who have had unusual reactions to such insects. Include in your reports the type of reactions (immediate and delayed symptoms), treatment; age, sex, and race of the patient; site of the bite(s); season of the year; any other associated allergies.

If skin tests and hyposensitization were instituted, I would like the report of both. Please note that it is the biting (not stinging) insect in which I am interested.

Claude A. Frazier, M.D.

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Asheville NC 28801

Virginia's Board of Medicine Acts To Insure Physician Competency

ROBERT C. GREEN, JR., M.D.
Winchester, Virginia

SINCE 1885 the Virginia State Board of Medicine has been the major disciplinary body of the state's medical profession. Until recently, however, the Board's effectiveness was always limited by inadequate and ineffective regulations as well as by a reluctance on the part of the profession to participate in disciplinary actions.

Approximately ten years ago, the Board noted an increasing demand by the public, press and, indeed, the medical profession itself to find more effective ways of dealing with sick, incompetent, and nonprofessional physicians. In response, the Board began developing new and more effective guidelines as well as legislative proposals to deal with these problems. Subsequently, the Board has greatly increased its surveillance, disciplinary actions, and rehabilitation efforts. It has also attempted to reassure both the public and the profession that meaningful effective action is now being taken to insure competency among Virginia physicians.

IT became apparent in 1966 that some form of psychiatric guidance was needed to deal with the increasing number of physicians seen for problems related to alcohol, drugs, senility, and mental illness. As a result, the Board appointed a psychiatric advisory committee consisting of three independent psychiatrists to conduct interviews and to evaluate this type of disciplinary problem. From this beginning a valuable system has evolved to provide continuing monitoring and advice concerning the treatment and handling of mentally ill physicians. In addition, the Board has developed a rehabilitation program for many of these mentally disturbed physicians. The system has functioned so successfully that it has recently been expanded into a regional concept with a doubling of psychiatric personnel. A psychiatric advisory service is now available to the Board in Norfolk, Arlington, and Charlottesville.

In 1965, the Board recognized that its responsibility for competence in the medical profession did not end with initial licensure but continued throughout the entire professional life of physicians. The Board therefore unanimously embraced the concept of mandatory continuing education for relicensure, and then developed this into a legislative bill which was introduced in 1972 at the General Assembly. Despite some opposition, this bill has been refiled each year and in 1975, it was redrafted with the unofficial cooperation of The Medical Society of Virginia. It is anticipated that a similar bill will pass the General Assembly in 1977.

THE Board formed a working relationship with the Virginia State Board of Pharmacy in 1973. This cooperative effort and the diligence of the pharmacy inspectors have led to a great increase in the incidence of cases of drug mishandling and addiction by physicians reported to the Board. At present, many of the Board's serious disciplinary actions arise from this service.

A further significant action occurred in the same year with the Board's sponsorship of a sick doctor act. Passage of this bill by the state legislature allowed the Board to limit or revoke a physician's license if, after proper investigation, he was found to be mentally or physically incompetent. This law made it possible to restrict or terminate a physician's prac-

Dr. Green is president of the Virginia State Board of Medicine.

tice before, rather than after, he committed acts of incompetence.

The publication of the names of physicians whose licenses had been placed on probation or revoked was begun by the Board in 1974. These names appear in "Board Briefs", a newsletter circulated to the members of the Virginia medical profession. Although greeted initially with some dismay by a few members of the profession, this action generally has been encouraged. Two years later, the Board felt ethically and legally obligated to extend publication of the Board's disciplinary actions by notifying all hospitals granting privileges to physicians whose licenses were placed on probation or revoked. It was strongly felt that the hospitals and their staffs were entitled to be informed of these disciplinary actions which were often associated with incompetence or limitation in performance.

THIS year the Board was empowered by a resolution of the state legislature to work with the Virginia Hospital Association and The Medical Society of Virginia to develop a "risk management program" that it was hoped would reduce the incidence of malpractice claims. As a result of this legislative request, the Board anticipates a further strengthening and tightening of disciplinary measures to protect the public and the profession from the consequences of incompetence and nonprofessional conduct.

Another significant action of the Board in 1976 was the hiring of a full-time investigator to help gather evidence in cases reported for serious infractions of the medical code. The present legal climate makes mandatory the accumulation of hard evidence in cases where revocation of a license is contemplated.

The Virginia State Board of Medicine is dedicated to insuring competence and ethical behavior among members of the medical profession. It is hoped that these new programs will contribute to making Virginia a leader in competent medical care.

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SOUTH RICHMOND'S ONLY COMMUNITY HOSPITAL

Medicine and the Law . . . .

THE LAW has increasingly subjected health care services to greater scrutiny and broader liability. In recent years, the courts have been imposing liability for the tort of "outrage," which involves the intentional infliction of mental suffering on another without physical injury. The aggrieved may be the victim himself or a third party. There are four elements involved in this tort. One, the wrongdoer's conduct was intentional or reckless. Two, the conduct offends against the generally accepted standards of decency and morality. Three, there was a causal connection between the wrongdoer's conduct and the emotional distress. Four, the emotional distress was severe.

In a 1971 Oregon case, a mother recovered for emotional distress when a physician refused to continue to treat her baby, critically injured in an auto accident. His refusal was made known to the mother in what was charged to be an extremely outrageous manner. In addition, the physician was charged with causing the child and mother to be subjected to inhuman considerations.

The Court of Appeals of Tennessee recently held that the tort of outrageous conduct was one in which punitive damages could be allowed in addition to compensatory damages for negligent conduct. The plaintiffs had brought suit against a hospital for breach of contract to bury a body and for alleged outrageous conduct thereafter. The story was this: Mrs. Rita Johnson's premature infant died soon after birth. The physician told a hospital floor nurse to tell the Johnsons that the hospital could handle the disposal of the body or that they themselves could arrange for burial. The nurse did not relate this information but simply told them that the hospital would probably take care of everything. The hospital retained the infant's body in the pathology laboratory. Later, while at her physician's office for her checkup, the mother was given her medical chart by the physician's nurse. She noted a report on the chart stating that the body could not be disposed of as a surgical specimen. When she confronted her physician, he instructed one of his nurses to accompany her to the hospital. There, an employee handed her the jar of formaldehyde containing the shriveled body of her infant. Following this episode, Mrs. Johnson suffered from severe physical and emotional trauma leading to the lawsuit.

The Court held that the jury could properly find that the defendant hospital agreed to handle the infant's body and failed to do so. It could also properly find that the conduct of the defendant in displaying the deceased infant was outrageous conduct. The physician was lucky in this case. He could have been sued under the legal doctrine of agency, since he had instructed the nurse as to what to say to the patient.

In another recent case, the Washington Supreme Court ruled that a husband had a cause of action in medical malpractice because the physicians and hospital failed to provide medical care for his wife, who had a terminal malignancy with extensive metastases. The husband claimed extreme emotional suffering resulting in physical injury because the defendants, under outrageous circumstances and exceeding the bounds of decency, abandoned his wife and refused to treat her. The Court held that the plaintiff had a cause of action for his own mental suffering.

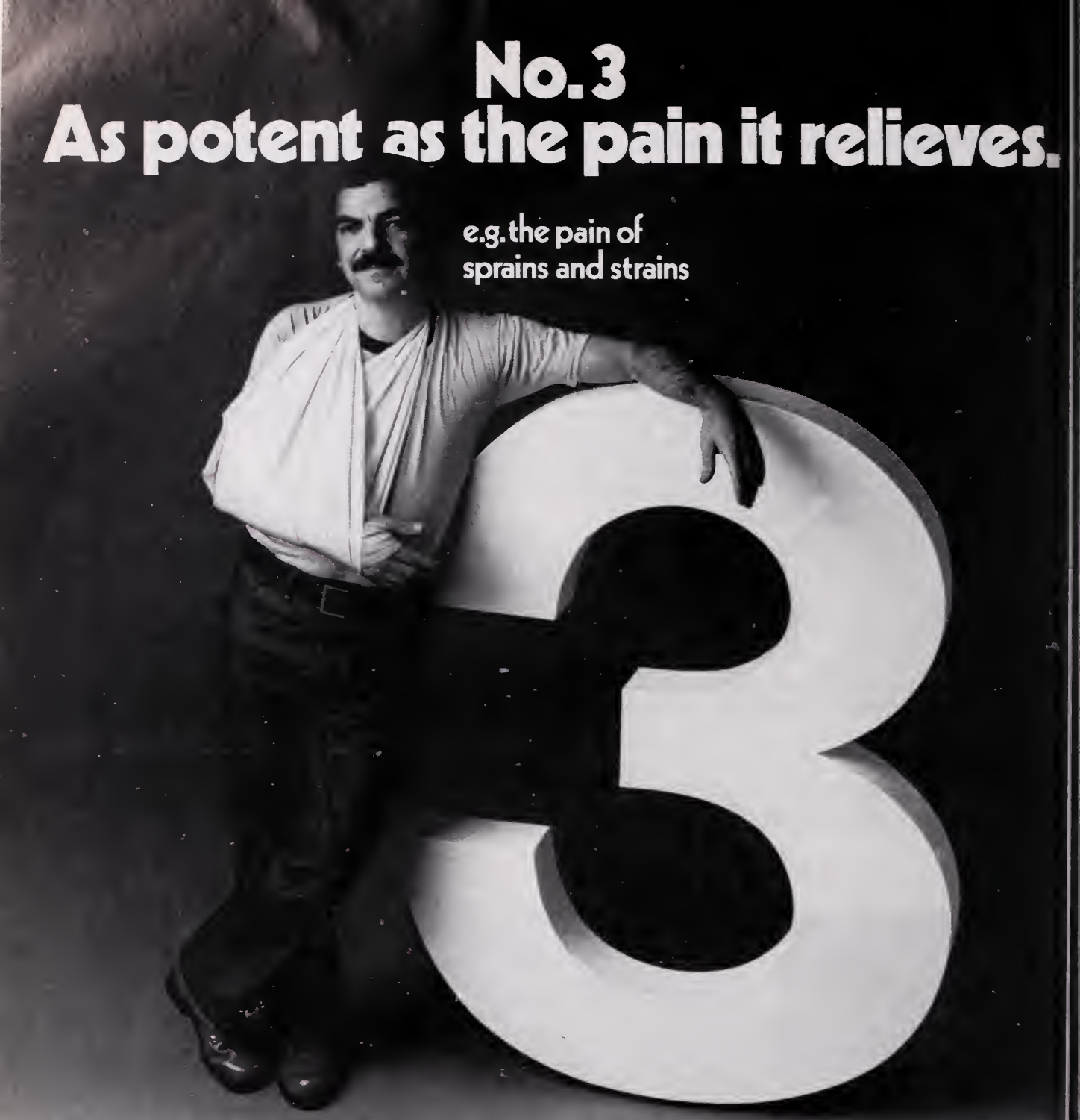
The first two cases represent an overt act of outrageousness; the third is an extension of the doctrine in which the failure to act was considered outrageous. The invocation of the tort of "outrage" is one more example of the increased willingness of courts to impose an all-pervasive liability on negligent physicians.

HAROLD L. HIRSH, M.D., J.D.

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The Medical Society of Virginia . . . .

Minutes of Council

A meeting of the Council of The Medical Society of Virginia was held in Richmond at Howard Johnson's Midtown Motor Inn on Sunday, May 23, 1976.

Members Present: Dr. Raymond S. Brown, Dr. W. Leonard Weyl, Dr. William R. Hill, Dr. Gervas S. Taylor, Jr., Dr. William J. Hagood, Jr., Dr. Harold L. Williams, Dr. Girard V. Thompson, Sr., Dr. George M. Nipe, Dr. Harry C. Kuykendall, Dr. James Hal Smith and Dr. C. Barrie Cook.

Others Present: Dr. W. Robert Irby, Second Vice-President, Dr. K. K. Wallace, Jr., Vice-Speaker, Dr. Harry J. Warthen, Editor Emeritus—Virginia Medical Monthly, Dr. William Stewart Burton, Dr. James S. Kitterman Dr. J. Latane Ware, Dr. Henry M. Snell, Dr. William E. Painter, Dr. George E. Broman, Dr. Robert V. Galliott, Vice-Councilors; Dr. William S. Hotchkiss, AMA Delegate; Dr. John A. Martin and Dr. Carl E. Stark, Alternate AMA Delegates; Dr. William Drucker, Dean, University of Virginia School of Medicine, Dr. Jesse L. Steinfeld, Dean, The Medical College of Virginia, Dr. James B. Funkhouser representing the Virginia Department of Mental Health and Mental Retardation, Dr. Eugene Perez, Director, Virginia Regional Medical Program, Dr. James Kenley, Commissioner Designate, State Department of Health, Dr. Robert Jackson, Department of Health, Dr. Gary Miller and Mr. John Bacon representing the Student Medical Association of the Medical College of Virginia, Mrs. Harold L. Williams, President, Woman's Auxiliary to The Medical Society of Virginia, Mr. Robert G. Stuart, Executive Secretary, VaMPAC, and Mr. William R. Miller, Attorney.

Flu Vaccine

Dr. Robert Jackson, speaking on behalf of the State Department of Health, brought Council up to date concerning plans for the mass immunization of Virginia citizens against the threatened swine flue epidemic. He indicated that $135,000,000 has been appropriated by the Federal Government to help finance the immunization over the Nation—a sum far from adequate. It has been estimated that the cost per dose for the vaccine will be 68 cents. Only 12½ cents will actually be available to the State from the Federal funds appropriated.

It was learned that testing is currently underway in an effort to determine basic information about the vaccine. Of paramount importance is the manufacturing time involved and its actual availability for use. It is hoped that the first injections can begin in July, and that everyone can be immunized by the end of November. Dr. Jackson discussed the liability factor, and indicated that informed consent will be used. Standardized forms for this purpose will be made available.

As matters now stand, trained paramedicals will give most of the shots. It is expected that Army medic teams will be made available at a later date should the need arise. It is also expected that many workers will be immunized in their occupational environment.

The Department of Health plans to cooperate with local medical societies wishing to spearhead immunization programs in their areas. Although the Department of Health will not involve itself where donations are concerned, it will leave any decisions in this regard to sponsoring organizations. The thought was expressed, however, that it might be best for all concerned to forego the collecting of donations for this particular program.

Executive Committee Reports

Dr. Brown reported that the Executive Committee had met for several hours in Richmond on Tuesday, May 18, for the purpose of reviewing the many items on the Council agenda. It was hoped that this preliminary review would assist Council in its deliberations and expedite the flow of business. The following items were included in the Committee's report:

A. Honorariums for Continuing Medical Education Survey Team Members

Council was advised that the Commission on Continuing Medical Education has voted not to accept honorariums for surety visits made thus far. In the future, members of the Commission serving on such teams will have only their expenses paid—no honorariums. Non-Commission members serving on survey teams will, in the future, be advised that only their expenses can be paid.

The Commission, however, requested Council approval for the payment of honorariums in the

amount of $75 should an unforeseen but valid need be indicated in the future. Such a need is not anticipated.

It was the Committee's recommendation, therefore, that the Commission be authorized to award honorariums in the amount of $75 should a need arise which it considers valid.

B. PR Program for Virginia Society for Ophthalmology and Otolaryngology

The Virginia Society of Ophthalmology and Otolaryngology is planning a positive public relations program featuring TV spots, newspaper articles, lectures, etc. The program is designed to educate the public concerning potentially blinding diseases and preventive medicine related thereto. The Virginia Society of O & O has obligated itself in the amount of $25,000 for the initial phase of the program, and has indicated that it would welcome financial assistance.

It was the Committee's feeling that the Virginia Society of O & O should be commended on the work it is doing and the PR program it is planning. The Committee believes, however, that The Medical Society of Virginia is not in a position to provide financial assistance at this time. Demands upon the Society are very great at the moment, and every effort must be made to conserve our badly needed funds.

It was the Committee's recommendation that Council express its regret of our inability to provide financial assistance at this particular time.

C. Irradiation Therapy to Head and Neck

Council was requested to consider a situation which has developed as a result of radiation used in past years for such things as shrinking tonsils, adenoids, and thymus glands. There are those who believe that recent developments indicate that recipients of this treatment should be notified and that such further treatment as might be necessary should be offered in a fairly standardized manner.

The Committee reported that, in its opinion, one or more articles by recognized specialists should be published in the *Virginia Medical Monthly*. In this way, physicians could weigh the facts as presented, and determine what course of action they should follow.

It was the Committee's recommendation that such articles be arranged by our Editors at the earliest possible moment.

D. Maryland Medical Staff Conference

The Greenbriar will be the scene of the Second Annual Maryland Medical Staff Conference on October 6-9. The Society has again been invited to serve as a co-sponsor—with no financial obligations. The conference is designed as an intense learning experience for hospital medical staff leaders, trustees and administrators. An outstanding faculty has been engaged.

It was recommended that the Society inform the Maryland Hospital Education Institute of its willingness to serve as a co-sponsor.

E. 1981 Annual Meeting

In keeping with the Society's policy of arranging annual meeting dates and locations as far ahead of time as seems practical, the Executive Committee recommended that the 1981 meeting be held at the Omni International Hotel, Norfolk, and the 1983 meeting at the Marriott Twin Bridges Motor Hotel in Arlington. Suitable October dates will be obtained at both locations.

F. Business Sessions for Interns, Residents, and Medical Students

AMA has recommended that state medical societies establish business sessions for interns, residents and medical students. The Committee reported that, in its opinion, the Society is presently doing all that it reasonably can for these groups. Courtesy membership is available to interns and residents, and component student medical societies are authorized under our By-laws. Approximately 240 students at the Medical College of Virginia are now active members of The Medical Society of Virginia.

There was considerable discussion concerning the advisability of having house staff officers attend meetings of Executive Committees of component societies. It was agreed that component societies should involve interns and residents as much as possible in their scientific and business affairs, and *a motion to this effect by Dr. Weyl was seconded and carried.*

G. Hospital Based Physicians

The Society has been urged by the Virginia Society of Anesthesiologists to adopt a definition of "hospital based physicians" as presented by the American Society of Anesthesiologists. It was mentioned that anesthesiologists have successfully resisted attempts to include them as hospital based physicians under the Medicare program. The definition offered is considered a statement of professional relationship—relevant to physicians other than anesthesiologists.

In discussing the definition, there were those who believed that the wording should be revised to some extent. Dr. Hagood considered the matter of sufficient importance to be referred to the House of Delegates with as much additional in-

OFFICERS AND COUNCILORS OF THE MEDICAL SOCIETY OF VIRGINIA, 1975-1976

President: Raymond S. Brown, M.D., Gloucester *President-Elect:* W. Leonard Weyl, M.D., Arlington

Past-President: William R. Hill, M.D., Richmond

Vice-Presidents: 1st, Gervas S. Taylor, Jr., M.D., Norfolk 2nd, W. Robert Irby, M.D., Richmond

3rd, Douglas E. Pierce, M.D., Roanoke

Executive Vice-President: Robert I. Howard, Richmond

State Commissioner of Health: Mack I. Shanholtz, M.D., Richmond

Editor Emeritus, Virginia Medical Monthly: Harry J. Warthen, M.D., Richmond

Speaker of the House: William J. Hagood, Jr., M.D., Clover

Vice-Speaker: K. K. Wallace, Jr., M.D., Virginia Beach

COUNCILORS	(District)	VICE-COUNCILORS
Harold L. Williams, M.D., Newport News	1st	William Stewart Burton, M.D., Nassawadox
Charles E. Davis, Jr., M.D., Norfolk	2nd	James Sidney Kitterman, M.D., Norfolk
Charles M. Caravati, Jr., Richmond	3rd	J. Latane Ware, Richmond
Gordon G. Birdsong, M.D., Franklin	4th	Henry M. Snell, M.D., Petersburg
Girard V. Thompson, Sr., M.D., Chatham	5th	Russell E. Herring, Jr., M.D., Martinsville
H. C. Alexander III, M.D., Roanoke	6th	William E. Painter, M.D., Lynchburg
George M. Nipe, M.D., Harrisonburg	7th	George E. Broman, Jr., M.D., Culpeper
Harry C. Kuykendall, M.D., Alexandria	8th	Nicholas G. Colletti, M.D., Woodbridge
James Hal Smith, M.D., Christiansburg	9th	Robert V. Gailliot, Marion
C. Barrie Cook, M.D., Falls Church	10th	Richard L. Fields, M.D., Fairfax

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates	*Alternates*
1975-1977	1975-1977
William S. Hotchkiss, M.D., Norfolk	John A. Martin, M.D., Roanoke
Michael A. Puzak, M.D., Arlington	Carl E. Stark, M.D., Wytheville
1975-1976	1975-1976
F. Ashton Carmines, M.D., Newport News	Percy Wootton, M.D., Richmond

formation as possible. *His motion was seconded and carried.*

A related motion by Dr. Weyl, directing that the matter be referred to Virginia's AMA delegation for follow-up on an unofficial basis, was seconded and adopted.

H. Winter Travel Plans

Although there is some question as to whether the Society should sponsor more than one trip for its members each year, there is reason to believe that many physicians are looking for a good one-week trip at reasonable costs. Consequently, the Executive Committee believes that a trip next February to Rio, at an approximate cost of $500, has definite possibilities, and would be well received. It hastened to add, however, that the trip should not be confused or compared to the annual two-week deluxe trip sponsored each year during the summer months. It stressed the importance of properly informing the membership as to what it might expect. Arthurs Travel Service would be the agency involved.

I. Alternative Professional Liability Programs

Dr. Brown explained how a letter, written by him to the President of the Physicians Underwriting Insurance Company, was used by the carrier for promotional purposes. The carrier expressed its regret and indicated that it was a result of bad judgment on the part of its personnel. The Executive Committee pointed out that the letter was never intended for publication, and was a sincere attempt on the part of Dr. Brown to clarify the Society's position by reporting the February 11 action of Council. That action reaffirmed an earlier action by the House of Delegates approving in principle the development of a professional liability program, administered by a Virginia physician owned and controlled company, as an acceptable alternative.

Later during the meeting, Dr. Kitterman reported that the Physicians Underwriting Insurance Company will quite likely apply for a license sometime during the week of May 24. The carrier plans to issue its first policy around mid-June. Latest reports indicate that the carrier is

counting upon an initial participation of at least 900 physicians.

J. Health Fairs

Although the matter of health fairs and laboratory tests was considered last year by Council, the House of Delegates referred it back for further study. The problem stems from the fact that results of tests taken at these fairs are, in most instances, sent to the physician who is expected to interpret them and make his findings known to the patient—often by phone.

The Committee reviewed the situation and agreed that the manner in which laboratory tests are handled at such fairs leaves much to be desired. The Committee believes strongly that, in the future, the responsibility for getting test results to the physician should be left entirely to the patient, who should then be required to bring them personally to the physician for such interpretation and follow-up as might be indicated. To proceed otherwise could possibly place the physician in a difficult and unreasonable position.

It was the Committee's recommendation that Council stress the patient's responsibility when such tests are made at health fairs, and clearly define the role of the physician.

After agreeing that the word "honorarium" should be changed to "consultant fee," *Council approved a motion by Dr. Weyl calling for the report of the Executive Committee to be adopted as amended.*

Continuation of Malpractice Campaign

A recommendation has been made that The Medical Society of Virginia retain the services of Mr. Ed DeBolt on a twelve month basis. A strong feeling exists that there must be no let-up in the Society's efforts to keep before the public and the General Assembly the continuing and increasing problems caused by the escalating costs of professional liability coverage.

Dr. Kuykendall expressed the opinion that our overall effort should be devided into two parts—public relations and lobbying. The feeling was expressed that Mr. Osburn and his assistants are having to do more than can reasonably be expected of them. Consequently, it might be necessary to provide additional help.

Mr. DeBolt discussed the work of his organization and stated that physicians must be willing to take the risk of stepping on toes when they undertake an all out, hard hitting type of campaign. He indicated that his fee of $2500 per month would be for professional services, and would not include expenses such as printing, postage, etc. Council was assured that such expenditures would always be cleared first with the State Office.

Mr. Miller expressed the hope that the Society is not permitting itself to over-simplify the problem. He cautioned Council that a solution to the overall malpractice problem had not yet been found, and that a major effort must be made to determine what the crisis is really all about and identify the underlying causes.

Dr. Hagood suggested that a Council retreat be held for the express purpose of delving into the problem.

The thought was also expressed that the entire tort system must ultimately be changed, and that the Society should seek to work as closely as possible with the Bar.

Dr. Taylor then moved that the services of Mr. DeBolt be utilized on a twelve month basis, and that a second assessment in the amount of $20 be authorized to cover the cost. *His motion was seconded.*

Dr. Kuykendall then offered an amendment which would authorize part of the funds derived from the assessment to be used for legislative education—should a need be indicated. *His motion to amend was seconded and carried.*

Dr. Taylor's motion was then adopted as amended.

State Board of Health

Council was advised that the terms of Dr. Robert Hutcheson and Dr. William Terry will expire on June 30 and that neither is eligible for reappointment. Also mentioned was the fact that the terms of Dr. Thomas Iden and Dr. Fletcher Wright will expire in 1977 and 1978, respectively. Here again, neither is eligible for reappointment.

The loss of these physicians means that, within a two-year period, the entire physician complement on the Board will be changed. It was agreed that the Society should make its nominations known to the Governor, and that this should be done within the next few days.

Dr. Hagood stated that members of Council should be provided a list of all openings on various governmental bodies not later than the first of each year. It was then moved that such a list be prepared for inclusion in the Delegates' packets and that qualifications for each appointment be provided. *The motion was seconded and carried.*

Bicentennial Medical Exhibit

Dr. Warthen announced that the Virginia Medical Bicentennial Exhibit, financed in part by

The Medical Society of Virginia, will officially open to the public on June 7. The Exhibit will be housed in the Richmond Academy of Medicine, and is expected to remain open for the entire five year period of the Centennial observance. It was learned that A. H. Robins has helped make the exhibit possible through a generous contribution of approximately $20,000. The contribution of The Medical Society of Virginia amounted to $2000.

There still remain some problems, however, inasmuch as the exhibit must be kept open on Saturdays. Inability to obtain a sufficient number of volunteer hostesses means that full-time attendants will undoubtedly be required. This means that additional funds must be obtained from some source, and the Society was requested to seriously consider additional financial assistance. In all likelihood, an additional $1000 will be necessary to keep the exhibit open until the end of the current year.

Dr. Cook moved that the Society explore ways and means of supplementing exhibit funds in order that the $1000 needed can be made available. *The motion was seconded and carried.*

Malpractice Research Incorporated

It was learned that inquiries concerning Malpractice Research, Inc., have been received from medical societies in California, Illinois, Ohio and West Virginia. Brochures describing the organization have somehow found their way into the hands of patients in these various locations.

Although several organizations and agencies are checking into the activities of this corporation, it apparently still remains in operation. Those responsible for its operation can now be identified, and this could prove helpful.

Contingency Plan

The Medical Council of Northern Virginia submitted a resolution urging that a contingency plan be established at the State level for the purpose of dealing effectively with any malpractice insurance crisis which might suddenly develop in the future. Dr. Weyl pointed out that care of the newborn and infants poses a potential problem because of the unsatisfactory provisions found in the Statute of Limitations. There was some concern that practice patterns might well be undergoing changes as a result of the malpractice problem. It was agreed that an effort should be made to determine just what changes, if any, have occurred and can be expected to occur in the months ahead.

It was recommended that this matter be referred to Mr. DeBolt with a suggestion that he work with Dr. Nipe's Committee in gathering the facts and figures we need at this time. *A motion to this effect by Dr. Kuykendall was seconded and adopted.*

Blue Shield

Mr. Gerald W. Blanchard, Coordinator of Professional Service, Blue Shield of Virginia, discussed ways by which physicians and Blue Shield can work together to their mutual advantage. He indicated that cost control is vitally important—more so now than ever before. The assistance and cooperation of physicians are especially needed where hospital admissions and length of stay are concerned. Mr. Blanchard went on to say that, by working together, the traditional fee-for-service system can be preserved.

It was learned that Blue Shield of Virginia is planning three one-day seminars during the late summer, and the locations will be Charlottesville, Norfolk and Richmond.

PSRO Poll

A poll of Virginia physicians will soon be conducted by the Department of HEW for the purpose of determining whether we will have one Statewide PSRO or the five regional PSROs presently in existence. The Medical Society of Virginia is, at the moment, firmly on record as favoring one PSRO for the entire State. Dr. Martin called attention to the fact that a great difference of opinion exists over the State, and that it is very important that an effort be made to achieve a greater degree of unity.

Dr. Robert Keely, President of the Virginia Professional Standards Review Foundation, stated that HEW has every intention of following through on its efforts to completely control the practice of medicine in this country. He stated that an all out effort is being made in Washington to make sure that the present five PSROs remain. Concern was expressed over the fact that opposition to The Medical Society of Virginia has been expressed in some areas as a result of the Society's firm stand on the issue.

Dr. Kuykendall was of the opinion that any discussion should essentially be concerned with the basic differences that exist between single and regional PSRO states.

Pointed out was the fact that a state PSRO Review Council is required when three or more PSROs exist in a particular state. Some physicians believe that the Council would serve as an additional buffer between the practicing physician and HEW. On the other hand, others believe that a strong central PSRO, dealing directly with HEW, would be much more effective.



Testing in Humans: Who, Where & When.

The weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P-M-A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005

A question was raised as to whether another letter to the membership concerning Society support for a single PSRO would be advisable. It was the concensus that such a letter very probably should be tried. Although a special session of the House was mentioned, it was the concensus that the time factor made it impractical.

Dr. Cook moved that Council again reaffirm the Society's position in support of a single PSRO for Virginia. *The motion was seconded and adopted.*

Utilization Review Regulations

The Department of HEW has recently proposed new regulations having to do with utilization review. Basically, they provide that hospital staffs will be permitted to establish specified categories for admission that would justify such admissions without further inquiry. For cases subject to review, only physicians can determine the lack of necessity, and only then after the reviewing physician has consulted with the admitting physician and another physician member of the Utilization Review Committee. Admissions must be reviewed within three working days. The proposed regulations also require each hospital to establish a preliminary screening procedure after admission to determine which cases should be referred to physician members of the Utilization Review Committee.

Council was reminded that earlier utilization review regulations had been set aside as a result of litigation by AMA in February, 1975. Some concern was expressed over whether the conditions set down in that court action were being met by the new regulations.

AMA is expected to make its comments known at an early date.

Insurance Committee

It was recalled that Council, during its February meeting, had postponed action on a recommendation from the Insurance Committee that sponsorship of the Society's retirement programs be withdrawn. That recommendation had been based on the fact that many options are now available to the individual physician and professional corporations and, consequently, sponsored plans no longer meet a real need. Council believed that the Bank of Virginia, serving as Corporate Trustee of three of the plans, should be consulted before sponsorship was definitely withdrawn. There was some thought that such action might unduly hamper the Bank in the performance of its duties.

It was learned that the Insurance Committee had met with representatives of the Bank, and that the advisability of sponsorship withdrawal had been considered from every angle. The Bank representatives noted that the programs had been originated by the current administrator and that, in their opinion, the same reasons for sponsorship remain valid today. The Committee believed, however, that the need of a separate administrator is increasingly difficult to justify.

It was brought out that the Bank's main objective is to see the plans realize their maximum potential. A great amount of money has been invested in them.

Council was then advised that the Committee recommends that the current administrator of the plans be dismissed and replaced by the Bank of Virginia, and that when an orderly transition to a comparable and acceptable plan can be accomplished, sponsorship by the Society be withdrawn.

Mr. Miller stated that, in his opinion, the Society is not in a position to discharge the administrator—although it can withdraw sponsorship of the plans. Consequently, the recommended procedure would be to give the administrator 180 days notice of that intent and provide him an opportunity to respond. This would pave the way for an orderly transition. Brought out was the fact that this action would apply only to the three so-called "corporate" plans, and not the Keogh program.

A motion to ultimately withdraw sponsorship by following the plan outlined by Mr. Miller was seconded and adopted.

Council was then advised that St. Paul has informed the Insurance Committee that it proposes to leave the mature rate for our professional liability program unchanged. The second year premium, however, will increase approximately 25%, in keeping with the previously announced orderly progression in the premium rate structure for the first three years of the claims made plan.

It was mentioned that an effort is being made to determine the significance of the "cost per physician" figures announced by the carrier. St. Paul has promised an early explanation.

It was also learned that a new classification plan will soon be in effect. Hopefully, the new plan will make it possible for physicians to be classified in a more realistic manner—thereby resulting in substantial premium savings for many.

Liability Insurance

A recommendation was made that the Society seriously consider providing liability insurance for its officers and employees in view of its involvement in Federal grants, employee retire-

ment programs, etc. Such insurance is now obtainable at reasonable cost, and it would seem advisable that it be authorized as soon as possible. Mr. Miller indicated that, in his opinion, the coverage had much to recommend it. A question was raised concerning coverage for members of Council, and it was agreed that this possibility should be investigated.

A motion was offered by Dr. Cook directing that necessary facts and figures on the coverage be obtained and presented to the Executive Committee for a final decision. *The motion was seconded and carried.*

Distribution of Malpractice Insurance Costs

The Society has been urged to take a more positive stand concerning a proposal by the Insurance Commissioner to re-distribute the cost of malpractice insurance by shifting a major part of the load to hospitals. This would mean that physicians would only be responsible for the insurance to cover their activities outside the hospitals.

The Commissioner's plan is set forth in House Bill No. 884, which has been carried over to the 1977 session of the General Assembly.

During the following discussion, the thought was expressed that there might well be some advantage in not taking a fixed position at this time. Brought out was the fact that the Virginia Hospital Association is opposed, and that some of its reasons appear quite valid.

A motion was then made by Dr. Weyl that the matter be referred to the Legislative Committee with the request that it study the plan in detail and report back to Council its findings and recommendations. *The motion was seconded and carried.*

VD Alliance

Dr. Charles Caravati, Jr., recently represented the Society at an organizational meeting of the Virginia Alliance for the Eradication of Venereal Disease. It was reported that Dr. Caravati believes this new organization has some definite possibilities, and that the Society should seriously consider becoming a charter member. The membership dues would be $35.

A motion by Dr. Weyl to join the Alliance was seconded and adopted.

Hopkins Report

Dr. Ware stated that considerable concern is being voiced concerning the future of the State Board of Medicine. Although the Society has been unable to obtain definite recommendations associated with the so-called "Hopkins Report," it has been advised that the Board will probably be faced with two alternatives—neither really acceptable. Either way, the Board would find itself in an administrative grouping of other boards.

Dr. Weyl moved that the Society go on record as supporting the present structure and independent status of the Board of Medicine, and express the hope that it will be permitted to remain unchanged in the future. *The motion was seconded and adopted.*

Next Council Meeting

A great amount of thought has been given to the subject of Council meetings in an effort to make them more streamlined and effective. Dr. Brown discussed the advisability of designating one or two meetings each year as Executive Sessions—attended only by voting members of Council. There was some opposition to the proposal, however, and Dr. Brown assured Council that it was merely one of several suggestions worthy of discussion. It was agreed that all those attending Council meetings under the present format have contributed greatly to its deliberations.

It was agreed that the time and location of the next meeting should be left to the President and Executive Committee.

Membership Application Form

A question was raised as to why the Society's membership application form contained a space for the designation of race. It was reported that some objection had been noted and questions raised concerning the need of such information.

The thought was expressed that Society records should contain as much data as seems reasonable on every member, and that information concerning race is often helpful for statistical purposes. Consequently, it was decided to leave the form unchanged at this time.

There being no further business, the meeting was adjourned.

Robert I. Howard, *Secretary*

APPROVED:

Raymond S. Brown, M.D., *President*

Oriental Rugs



My name is Amir Zinat; I am Iranian. Years ago as a graduate student in the U.S., I noticed the big difference in the price of Orientals in my homeland and here. I have chosen, as my business, to sell these rugs at more reasonable prices. These rugs are selected by natives, are considered good investments and are exchangeable.

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1. Your home is not a museum; it is a place for your comfort, pleasure and relaxation. When selecting an oriental rug, first evaluate how much you like a particular rug and then consider how it complements your decor.
2. All sizes and colors of Oriental rugs are available, suitable for every room in your home including the bathroom, hallways and steps, and a child's room. The money you are willing to invest in a rug should be relative to the degree of its use and enjoyment. Furnish with rugs first the rooms which are used most often.
3. When you have found several rugs you like, compare their prices. If two similar rugs vary considerably in cost, be sure you do not pay the higher price for very minor differences.
4. Color and design (the balance of different parts of patterns and the proper coordination between border and field) are important considerations in selecting a rug.
5. Do not hesitate in selecting a rug which to some may appear "too loud" or "too strong" since soft colors and simple designs often lose their novelty sooner in the home.
6. Oriental rugs are named after the village or, more often, the region of their origin. The quality of a rug may vary greatly regardless of the name. You should judge a rug by its individual merits (workmanship, wools, use of color and design) and not by its name or signature alone.
7. Some irregularity of shape, color, design and workmanship is acceptable in a handmade oriental rug. However, the discrepancies should not be extreme.
8. Natural silk rugs are expensive and are good investments. Be selective in your choice since some synthetic silk rugs are also available.
9. In antique rugs (50 years and older) age and condition are significant factors in judging the value of a rug. This does not necessarily mean that all older rugs have higher value. If a rug is old, it must be in very good condition, otherwise do not consider purchasing it.

I would be happy to help you learn more about Orientals and assist you in any way in your selection.

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Richmond, Virginia

Woman's Auxiliary . . . .

Success Story: Student Loans and School Gifts Reach New Highs

It is now 13 years since the AMA-ERF guaranteed loan program was initiated, and in that time Virginia has made 710 loans totaling $835,650, with 67 being in effect at the present time. Stop and think what benefit has been given to these students who might not have been able to continue with their medical educations if it were not for the efforts of The Medical Society of Virginia and its Auxiliary!

Often we are asked, "How does the loan guarantee program operate?" The procedure is this. For every $1 raised, the banks will loan $12.50. A "loan security fund" is maintained, equal to about 8% of all outstanding notes on deposit. The banks actually make the loans. A student who has completed one semester of medical school may obtain a loan application from the office of the medical school dean. When he has filled it out, he returns it to the dean for his approval, and it is then forwarded to the bank servicing the area. In the Virginia area it is the Riggs National Bank of Washington.

A student may borrow up to $1,500 in any 12-month period and up to a total of $10,000 over seven years, provided his educational loans from all sources do not exceed $20,000. During his training, he must pay interest charges but nothing on the principal. When he goes into practice, he starts paying back the principal but is allowed to take up to ten years to do so. If a borrower defaults, the AMA-ERF buys his note from the bank and assumes the responsibility of collecting the loan and interest. The default rate is very low, about 1%; many of these come about through death or illness.

The year 1975 saw an upsurge in loan applications, with 3,737 new loans being granted over the nation. This surpasses all previous years. With the continued escalation in medical school tuition, it is apparent the need for more and more loans will correspondingly increase. In the 13-year period of the program, the national total of loans granted is 58,936 totalling $69,368,075.

The other AMA-ERF program, that of giving unrestricted funds to the medical schools, is also having strong success. In 1975, Virginia reached an all-time high of over $37,000 in contributions to the three medical schools in our state. The way the contributions are going in 1976, it should be an even better year coming up. This program, too, is of increasing need, for the financial demands made on the schools in these times are almost more than they can contend with.

We look to you, Virginia physicians and Virginia physicians' wives, to help with contributions and fund-raising projects. You will be aiding young men and women to continue with their medical curricula, and you will be giving critical financial assistance to Virginia's medical schools.

JOANNE CLARK

Breast cancer was the topic of a symposium sponsored recently by the Richmond Auxiliary at St. Mary's Hospital, Richmond. The sponsor-

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ship was shared by the American Cancer Society, a rescue squad, hospital auxiliaries and the Medical College of Virginia nursing staff. And the Roanoke Auxiliary chose breast cancer as the topic of one of its recent meetings.

* * * * *

"Your Lungs, Your Life," a panel discussion on pulmonary disease, was presented recently at the Fairfax, Virginia, Hospital as a project of the Woman's Auxiliaries of Arlington, Fairfax and Alexandria, joined by the American Cancer Society, the Heart Association of Northern Virginia and the Potomac Lung Association.

A slide-sound series on the air pollution problems confronting metropolitan Washington was shown, followed by two short films dealing with the health effects of smoking. Dr. Thomas M. Fulcher, thoracic surgeon, spoke on the anatomy and physiology of the lungs. The health effects of smoking were detailed by Dr. Steven M. Zimmet, pulmonary disease specialist.

* * * * *

The Fourth Statewide Conference on Health Education, held in Roanoke, was attended by two officers of the Virginia Auxiliary: Mrs. William Gordge, president-elect, and Mrs. Charles Smith, project bank coordinator, who participated in a workshop on volunteers in consumer health.

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Virginia's Medical Assistants Convene in Roanoke

Virginia's medical assistants gathered in Roanoke recently, aided and abetted by Virginia physicians, and elected new officers. They are Lonie Kanak, Richmond, president, who assists Dr. Gus V. Jackson, Jr.; Jeanette Cocke, Chesapeake, president-elect, who manages Dr. Donald Levy's office; Barbara Whitehead, Hampton, vice-president, medical assistant to Dr. A. W. Douglas; Karen Schumm, Richmond, secretary, who works for the Medical Specialists doctors at Retreat Hospital; and Virginia Keeter, Virginia Beach, treasurer, who is in charge of the office of Dr. John Franklin.

This was the 20th annual convention of Virginia's medical assistants, who are joined in a lively organization with the formidable title of Virginia State Society of the American Association of Medical Assistants (AAMA). There were 125 representatives of the Society's 16 chapters at the meeting, during which three new chapters were chartered: the Potomac chapter (Triangle-Quantico), Southside (Halifax County) and Loudoun County.

Participating throughout the convention were these physician-advisors: Dr. Ralph E. Hagan, Richmond, and Dr. Charles M. Earley, Virginia Beach.

Roanoke physicians contributed incisively to the convention. Drs. E. R. McDannold and Richard R. Chamberlain read papers related to their specialties, Dr. Robert L. A. Keeley was master of ceremonies for the Saturday night banquet, and Dr. Jimmy W. Farley acted as convention chaplain.

Medical assistants who are members of the Society may take extensive training qualifving them as Certified Medical Assistants, or CMS's. About a dozen Virginia women have completed this demanding course. One of them is Dorothy Sellars, CMA, who keeps Dr. Hagan's office on the qui vivre. Mrs. Sellars holds national office as an AAMA trustee; she attended the convention as the official AAMA representative and installed the Society's new officers.

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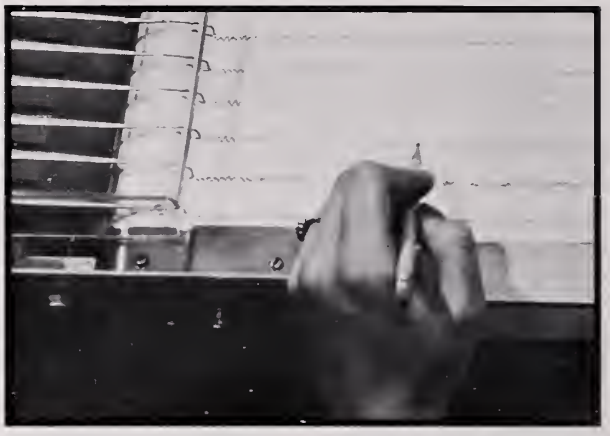
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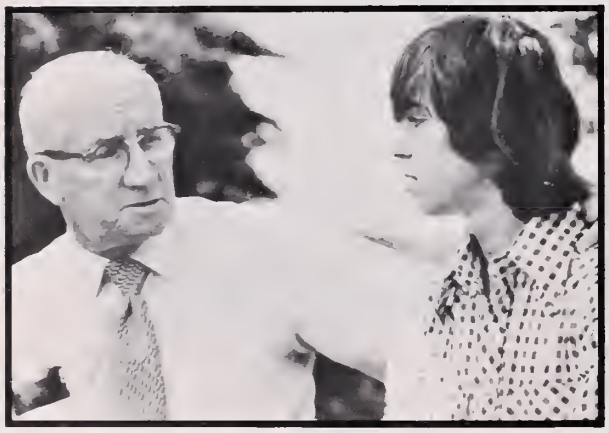
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Obituary . . . .

Jesse Miller Tucker, Jr., M.D.
Huddleston, Virginia

Dr. Jesse Miller Tucker, Jr., who faithfully served the Huddleston community in general practice from 1952 until his death, died on March 14 at the age of 53 years. Dr. Tucker graduated from the University of Richmond and the Medical College of Virginia. He was a veteran of World War II and had belonged to The Medical Society of Virginia for 23 years. He is survived by his wife and four children.

William Michael Bolt, M.D.
Norfolk, Virginia

At the age of 37 years, Dr. William Michael Bolt died April 17 in the University of Minnesota Hospital, Minneapolis, of complications following a kidney transplant. Dr. Bolt practiced diagnostic internal medicine in Norfolk, where he was also assistant professor of medicine at Eastern Virginia Medical School and secretary of the department of medicine at Norfolk General Hospital. A native of Charlotte, North Carolina, Dr. Bolt was a graduate of the Bowman Gray Medical School, Winston-Salem. He is survived by his wife, two daughters and two sons.

Clark H. Hagenbuch, M.D.
Roanoke, Virginia

At the age of 92 years, Dr. Clark Henry Hagenbuch died April 20 in a Roanoke hospital. From 1922 until his retirement in 1949, Dr. Hagenbuch was health and recreation director of the Norfolk and Western Railway. He gave generously to the community, as president of the Roanoke Tuberculosis Association, as one of the original members of the Roanoke Board of Health, as an organizer of Roanoke's blood center, and as the staff physician of the area's first bloodmobile. He had belonged to The Medical Society of Virginia for 63 years.

Robert Burns McEwen, Sr.
Wakefield, Virginia

At the age of 63 years, Dr. Robert Burns McEwen, Sr., died May 1 in Wakefield. A native of Richmond, Dr. McEwen was graduated from the Medical College of Virginia and served his internship at Stuart Circle Hospital, Richmond. He was a general practitioner in Wakefield from 1938 until his retirement in 1969 and for 20 years was medical examiner of Sussex County. He is survived by his wife, two daughters and one son.

Garrett Dalton, M.D.
Radford, Virginia

At the age of 73 years, Dr. Garrett Dalton died May 4 in Naples, Florida, where he had lived part of each year following his retirement from the practice of obstetrics. Dr. Dalton was a native of Carroll County and was educated entirely in Virginia; he was honored by his first alma mater, the College of William and Mary, by appointment to that college's Board of Visitors, and he received his medical degree from the Medical College of Virginia. Dr. Dalton found great satisfaction in energetically supporting the Republican party, attending state and national conventions as a delegate. He is survived by his wife and two daughters.

Frederick Bruce Forward, Jr., M.D.
Harrisonburg

Dr. Frederick Bruce Forward, Jr. died in Harrisonburg, Virginia, on March 31, 1975. He had been a specialist in the family practice of medicine in Harrisonburg for thirteen years.

He was born in Iowa City, Iowa, on August 14, 1933. His premedical education was completed at the University of Virginia in 1955, and he continued in his medical education at the University of Virginia and was granted his Doctor of Medicine degree in June of 1959.

He served an internship in the U. S. Air Force Medical Center in Lackland Air Force Hospita in Texas. He served a three-year tour of duty i the United States Air Force from June 1959 t June 1962. During that time, he also completed primary course of aviation medicine at the U. S Air Force Aerospace Medical Center at Brooks Air Force Base in Texas and was stationed at Yokota Air Base in Japan for one and one-half years.

In 1962 he entered the family practice of medicine in Harrisonburg, where he continued to practice until his death. He was certified by the

American Board of Family Practice and was a member of the Rockingham County Medical Society, the American Academy of Family Physicians, and the Rockingham Memorial Hospital Medical Staff. He was a past president of the Medical Staff and a past chairman of the executive committee of the Medical Staff. He was also a member of the Virginia Medical Society and the American Medical Association. He was a man of strong convictions and was active in the business and professional community.

He is survived by his wife, three children, and his parents and brother.

Therefore, now be it RESOLVED that a copy of this Resolution be spread on the minutes of the Rockingham County Medical Society, a copy to be sent to the family, and to the Medical Society of Virginia.

Rockingham County Medical Society

William E. Daner, M.D.
Richmond, Virginia

The Richmond Academy of Medicine lost an outstanding member on March 10, 1976. It is with sadness and humility that we recognize this loss.

Dr. William E. Daner was born at Paden City, West Virginia. He was the son of George Daner and Clara Ankrum Daner. His father was a skilled glass artisan and headed the local glass factory. Bill attended the local schools and was graduated from Magnolia High School at New Martinsville, West Virginia. He was graduated from Ohio State University and later received his M.D. degree from the Medical College of Virginia, class of 1941. While in medical school, he was an outstanding student and was a charter member of the Brown Sequard Chapter of Alpha Omega Alpha Honor Medical Society. He was also a member of Alpha Sigma Chi, honorary leadership fraternity, and Phi Chi medical fraternity. He interned at the Medical College of Virginia Hospital from 1941 to 1942. In 1942 he entered the Medical Corps of the U. S. Army and was assigned to the surgical and orthopedic service of the 45th General Hospital, serving in the North African and Italian theaters during World War II.

In Italy, he was in charge of the Brazilian casualties and instructed the Brazilian medical officers in handling battle casualties. From this, many enduring friendships were made with members of the medical profession in Brazil. The zenith of his army career was reached when he married 1st Lt. Valentina Lontkowski of the Army Nurse Corps. Following demobilization Val and Bill returned to Richmond and raised a fine family of five wonderful children, William, Jr., Sandra, Erica, Lisa, and Gary, who survive him.

Bill completed his specialty training in orthopedic surgery at McGuire Veterans Administration Hospital and the Crippled Childrens Hospital. In 1947 he entered private practice with Drs. H. Page Mauck and R. D. Butterworth. He was a charter member of the West End Orthopedic Clinic. He was on the teaching staff of the Medical College of Virginia and gave freely of his time instructing the resident staff. He was in charge of the Crippled Childrens Clinic at Heathsville, Virginia. He was on the staffs of the Crippled Childrens Hospital, Retreat for the Sick Hospital, Sheltering Arms Hospital, St. Mary's Hospital, Chippenham Hospital, and Johnston-Willis Hospital, having served as chief of orthopedics at the latter since June, 1971. He was consultant in orthopedic surgery at Kenner Army Hospital at Fort Lee, Virginia.

Dr. Daner was a member of the Richmond Academy of Medicine, the Medical Society of Virginia, the American Medical Association, the Virginia Orthopedic Society, the American Academy of Orthopedic Surgery and the American College of Surgeons.

Bill Daner was an outstanding diagnostician and skilled surgeon. He was a kind man, always considerate of the feelings and anxieties of his patients. Many foreign physicians experienced their first real welcome and warm sense of belonging while guests in the home of Bill and Val. He was a genial host, boon companion, devoted husband, loving father and loyal friend. He loved his family, his profession and his country. He was a good and gentle man.

Therefore, be it resolved that the Richmond Academy of Medicine and our country has lost one of its most beloved, patriotic and able physicians; that this Academy record its sorrow at his untimely death; that a copy of this resolution be kept on file with this Academy; and that a copy be sent to his bereaved family.

Respectfully submitted:
Walter H. Buffey, M.D.
Julius C. Hulcher, M.D.
Adney K. Sutphin, M.D.
R. D. Butterworth, M.D., *Chairman*

Your help in making this listing comprehensive and current will be very much appreciated. Please address news of the deaths of members to the Managing Editor, 4205 Dover Road, Richmond VA 23221.

BUREAU OF HEALTH EDUCATION
J. Robert Anderson, Director

ARTIFICIAL INSEMINATION

The use of artificial insemination has become a means of providing children for otherwise barren marriages. While the use of artificial insemination has increased, the legal aspects which should define the procedure and its ramifications often are unclear. Is a woman guilty of adultery if she is artificially inseminated? Is a child born through artificial insemination legitimate? What are the physician's responsibilities regarding artificial insemination.

Definitions

Terminology relating to artificial insemination is considered in terms of the source of the donor sperm.

- Artificial Insemination: a mechanical method by which fluid is introduced in a woman to make her pregnant.
- Artificial Insemination Homologous (AIH): the sperm supplied comes from the husband.
- Artificial Insemination Heterologous (AID): the sperm supplied come from someone other than the husband.
- Donor: Any male human from whom semen is obtained and mechanically introduced into a female to cause pregnancy.
- Pooled Specimen (AIHD): refers to a specimen which is composed of both the husband's sperm and the donor's sperm.

Adultery

The question of adultery is raised only with regard to AID; in AIH, the husband's own reproductive powers are used to cause impregnation, and a question of adultery would be unlikely. There seems to be a trend in court rulings indicating that AID with consent of the husband does not constitute adultery on the part of the wife. In the absence of any legislation which directly addresses the question, however, there is still room for speculation in many jurisdictions.

Legitimacy

The Virginia Statute states quite plainly that any child born to a married woman and conceived by means of artificial insemination performed by a licensed physician with the consent of the woman and her husband, shall be presumed to be the legitimate natural child of the woman and husband.

Responsibilities of Physician

The responsibilities of the physician performing AIH are similar to those which are associated with the performance of any medical procedure: to exercise due diligence, respect the confidence of his patient, and use best skill and judgment. He must follow the accepted practice of the locality in which insemination is performed.

The responsibilities of the physician performing AID are more complex:

1. *Fertility investigation:* This is done for each couple seeking artificial insemination, and attempts to ascertain the best time and method of artificial insemination.
2. *Ascertain the couple's emotional stability:* Both husband and wife should be reasonably well-adjusted individuals, and they should feel that they have a stable marriage.
3. *Donor investigation:* The donor should be a married man and already the father of a normal child. He should report no knowledge of hereditary disease and should be of above average intelligence. He should also be a blood type which is compatable with the wife's ABO and Rh genotype. An effort should be made to match the donor to the husband by somatic type, skin, hair and eye coloration whenever possible. The physician has the ultimate responsibility in donor selec-

Prepared by John L. Fitzgerald, B.A., Candidate for the M.H.A. degree at the School of Allied Health Professions, Medical College of Virginia, Richmond.

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tion. If the conception of a defective child can be traced to the physician's negligence or carelessness in choosing the donor, the physician might be liable in an action for malpractice. In addition, the physician must assure that the identity of the donor is not known to the parents and vice versa.

4. *Sperm Collection:* This should be conducted with reasonable care so as to preclude any liability due to damage or contamination of the sperm through negligence.

5. The physician should see to it that these proper consents are given:
   a. The wife should consent to preclude a technical battery.
   b. The husband should consent, because the procedure affects and involves the marital relationship:
   c. The donor should consent in writing to the unrestricted use of his sperm that he supplies and state that he will make no effort to ascertain the identity of the husband and wife involved.
   d. It would be desirable to obtain the consent of the donor's wife.
   e. The physician should have permission to use his own best judgment in selecting the donor, and the use of a pooled specimen.

Who May Perform Artificial Insemination?

In Virginia, under the statute which defines the legitimacy of a child born through artificial insemination, it is clearly stated that a licensed physician must perform the insemination.

Conclusion

Physicians, attorneys, patients, and everyone involved with the practice of AIH and AID, must be alert to the areas of potential liability. The legal conflicts regarding AID which have reached the courts have been few in number; these few cases have been ruled upon with very inconsistent results. One must also consider that the practice of AID carries with it many sociological, psychological, philosophical, and theological implications, all of which may bear heavily on those involved. There is a lack of legislative guidelines which regulate artificial insemination. Until the legal rules are clearly established, one should approach artificial insemination with caution.

A resource for therapies, including a school for emotionally disturbed children

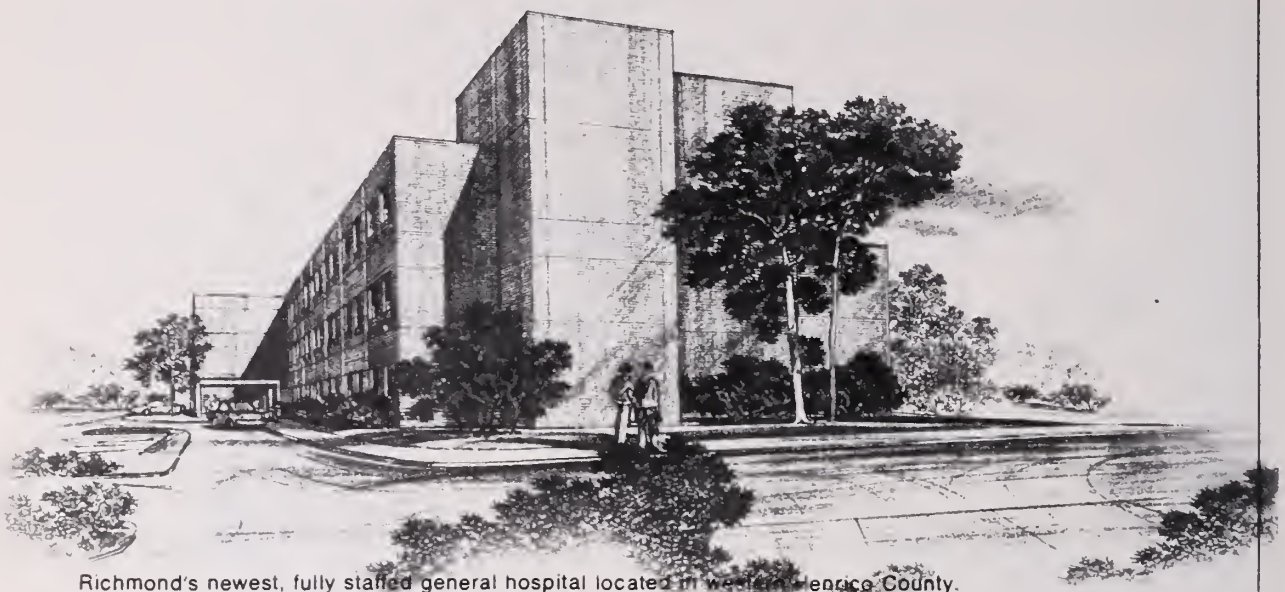
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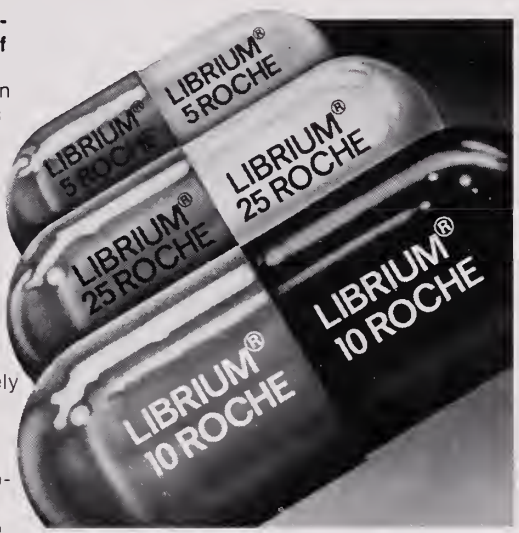
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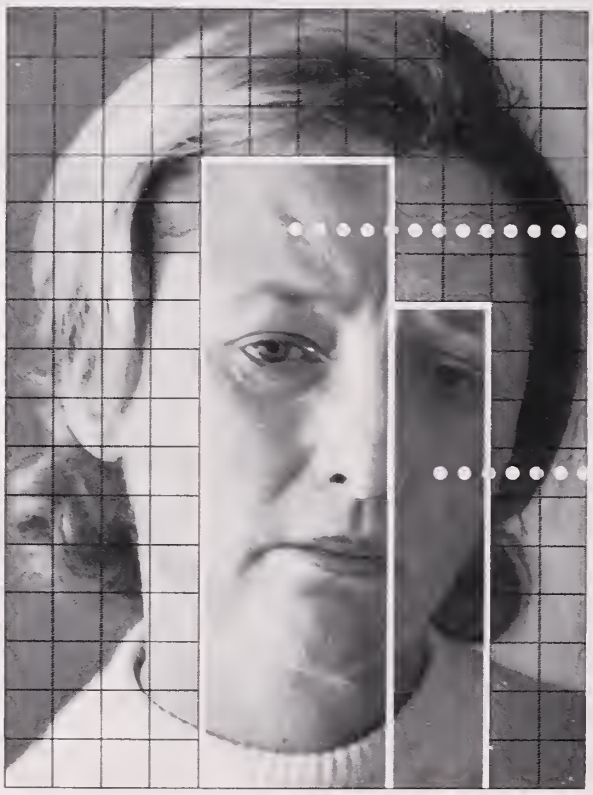
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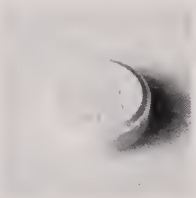
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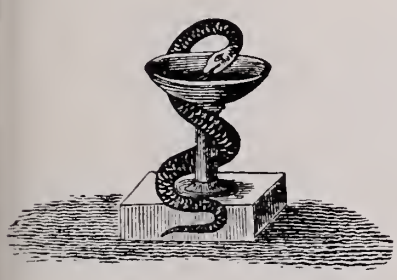
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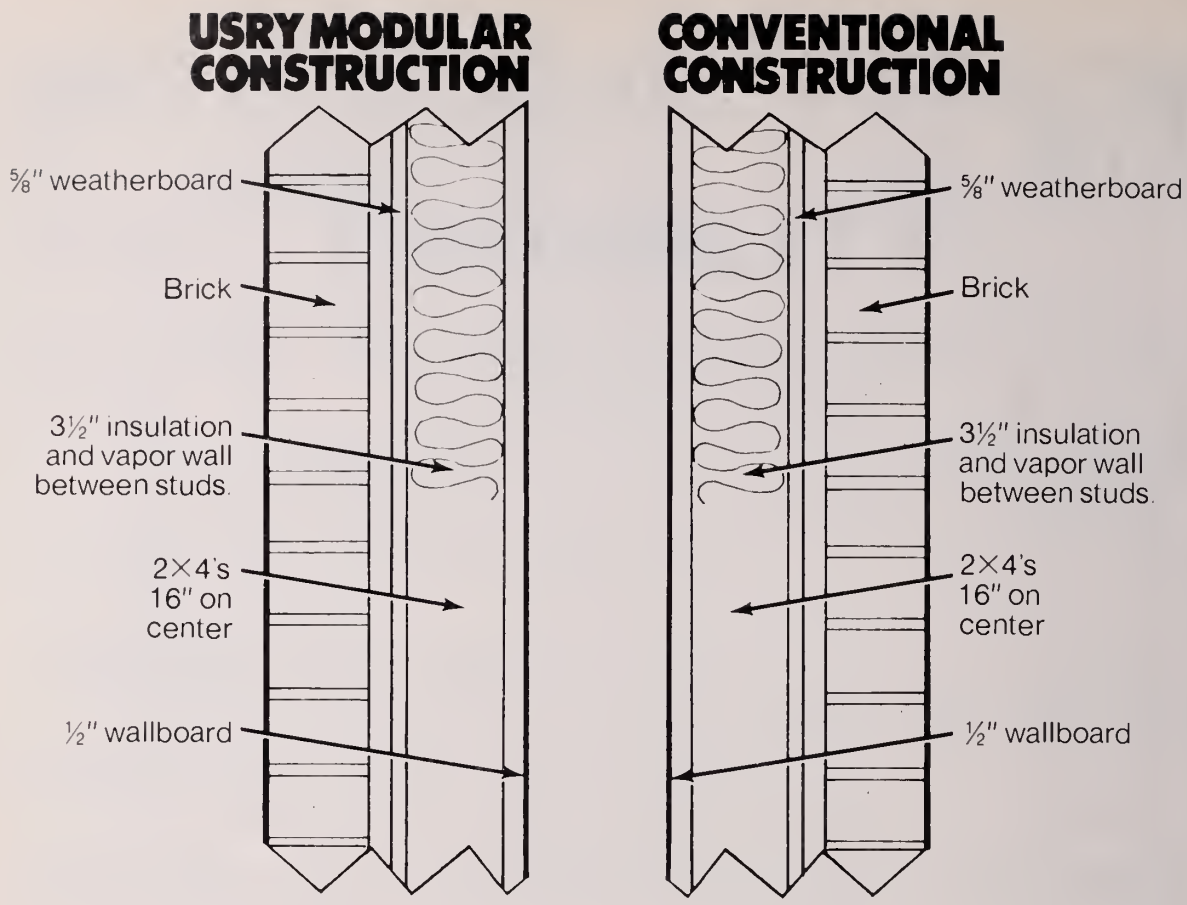
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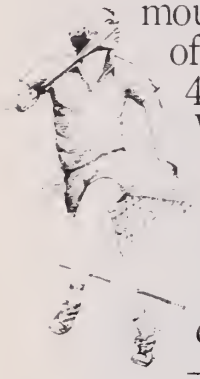
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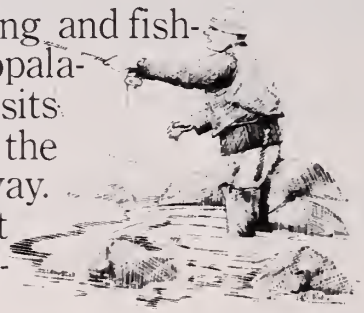
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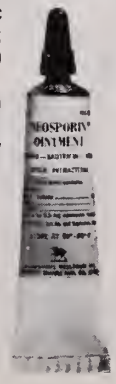
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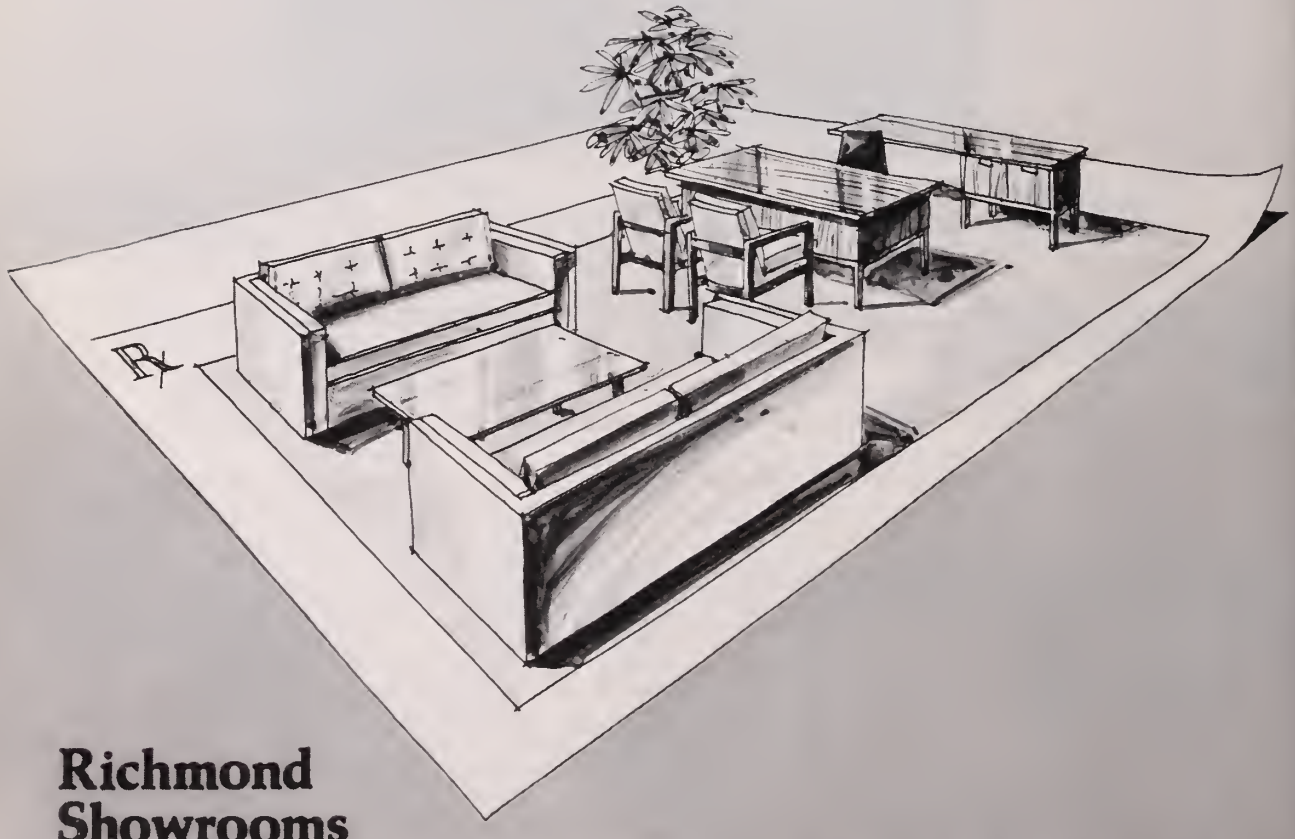
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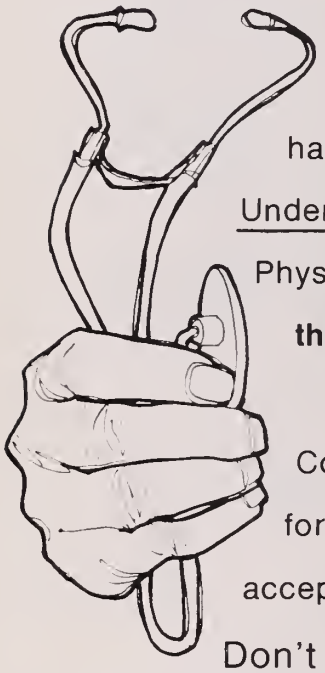




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VIRGINIA MEDICAL

Volume 103 August, 1976 Number 8

Doctor Shell's House Call: A Challenge from the Past

By John A. Owen, Jr., MD,
Charlottesville, Virginia

". . . No, Dr. Shell could not have pleased the peer reviewers, because he was not exerting proper judgment in the overall management of his practice. . . ."

AMONG my favorite relatives is a childless, middle-aged couple whom I shall call Uncle Roland and Aunt Elva. Once upon a time they had a harrowing medical experience whose every unvarying detail I have heard recounted many times.

Uncle Roland was struck suddenly by that ubiquitous "GI bug" which causes nausea, vomiting and diarrhea, all of which were 4+ that fateful day. Aunt Elva summoned their family doctor (whom I shall call Doctor Shell), who promptly made a house call, examined and diagnosed Uncle Roland's illness and wrote out his prescriptions. At this point, Aunt Elva says, she became somewhat distraught.

"Doctor Shell," she said, "Roland is as sick as a mule, and I don't have a soul to stay with him while I go to the drugstore. Now you sit right down in that chair beside his bed and if you're not here when I come back, I'll shoot you."

In due course she returned and found what she always describes in tones of mingled triumph, incredulity and awe: "And do you know, the old thing was still a-sitting there!"

Doctor Shell has been dead and in his grave for many a year (Uncle Roland and Aunt Elva, though spry as ever, are no spring chickens either), but somehow this story has always epitomized to me one of the intangibles of medical care: the willingness to sit there and give comfort when there is no other treatment to give.

If this vignette had occurred today, one might speculate how Doctor Shell should go about establishing a

". . . Why are the goals of the system and the needs of the patient so far apart? . . ."

proper fee for that protracted house call. Blue Shield of course permits a special fee for intensive and specialized care rendered at the bedside but might justifiably look askance at the specialized care of "just a-sitting". After all, anyone can do that.

Had Medicare been in effect then, its reimbursement process would also have been long and tortuous. Certainly the standard fee for a house call would be authorized but not a charge for the extra time; that would condone an indefensible inefficiency of the health care system, with the provider rendering a basic service and then dawdling for an unacceptable period of time at the bedside. By all the customary indices of cost accounting, Dr. Shell spent far too much time on that house call, which is even worse than not enough because it flies in the face of cost containment.

So much for third party payment. How would Doctor Shell fare at the hands of those carrying out peer review, measuring his professional performance against the validated criteria for the care of nonspecific gastroenteritis? Some peers might argue that making a house call was wrong, that Uncle Roland should have been transported via rescue squad to the nearest emergency room where he could get a better workup, intravenous fluids and even hospital admission if necessary. But on due reflection medical consensus would surely agree gastroenteritis is a highly variable affliction, and sometimes a house visit is entirely appropriate. However, even a jury of peers might balk at the protracted duration of that house call, for other reasons equally cogent. How many patients were waiting back at the office? How many phone calls were coming in with no one to respond? Who was supervising the paramedical personnel? No, Doctor Shell could not have pleased the peer reviewers, because he was not exerting proper judgment in the overall management of his practice, in the delivery of the highest quality and quantity of health care per unit of practice time.

In summary, it is crystal clear that this fabled house call which Uncle Roland and Aunt Elva remember so fondly is unsatisfactory by every modern standard of medical care: it is suspect, Grade B medicine, and Doctor Shell should be ashamed of it. But why must this be so? Why are the goals of the system and the needs of the patient so far apart?

Without realizing it, we seem to have stumbled into a serious dilemma. We are sincerely dedicated to the goal of efficient care for all our patients, but every now and then we feel a strong urge to expend lots of time and attention on one particular miserable sufferer. These two goals, more and more, are going to collide, and then what should we do?

Today the shibboleths of the system are on everyone's lips and minds: cost containment, utilization review, quality assessment, preadmission certification, maximum allowable cost, defensive medicine, etc. Fenced in by forms, guidelines, regulations, criteria and continual review of everything we do, we may be tempted to forget about using our mere presence as a therapeutic aid. It's just too much of a hassle—and a somewhat shame-faced hassle at that—to persevere with the confrontations that inevitably result when we try to justify the professional fees involved. So we conform. If the system won't pay for it, why do it?

But this is an extremely serious decision, even if (especially if) made unconsciously. It is no light matter for patients to be deprived of such therapy, the oldest and often the most powerful (surely the least toxic) in the medical bag. Throughout the centuries sick people have been strangely comforted by the watchful presence of one who was dedicated to their recovery, even though his drugs and techniques may have been pathetically ineffective.

By the same token, we are depriving ourselves also of tremendous gratification—the open willingness to sense an unspoken need, the all-out dedication of personality and purpose to meet that need, the mysterious thrill of succeeding somehow, of winning a shared gamble at high stakes. And always devotion "above and beyond" reaps gratitude, trust and affection "above and beyond".

These intangibles, unfortunately, cannot possibly be defined or quantified to the comprehension of your average, workaday computer, and so there cannot possibly be any room for them in the system. Hence they must go. But if they go, will we not have lost the essence of the art of medicine? Will we not spiritually begin to die also? What is to be done?

The answer is clear. We must work outside the system. We must give ourselves away.

Actually we should be grateful for the system, it gives us something to subvert. (Much better to measure our humanity against *that* than against our own personal stodginess.) Patients, like children, treasure most the spontaneous, impulsive act that says, "To hell with the system, I want to do this for you anyway." But having said so, we must go on and do it—and expect no financial return. Because to defy the system and still to expect to get paid is no defiance at all.

The challenge, then, is to anticipate those ubiquitous

. . . The answer is clear. We must work outside the system. We ıust give ourselves away. . . ."

ituations where the concept of the physician as a pro-ider unit in the health care system collides with the oncept of the physician as one who cares. Then we ıust demonstrate that care, with a touch and a smile, nd give it away for free. Simple enough? Yes. In-ovative? Not at all. Older, wiser, kinder readers, who ave done this all along, will recognize the message as coming straight out of *Magnificent Obsession,* Lloyd Douglas' best-seller of the '30's.

I make no apologies for that. Physicians today seem to be obsessed with financial headaches and adversary relationships with just about everybody. Maybe it's time for an obsession that's magnificent.





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Factors Influencing Tests for Infection and Inflammation

By Marion Waller, PhD, *Richmond, Virginia*

Four laboratory tests performed on 236 persons showed a positive correlation with the erythrocyte sedimentation rate when that test was negative or strongly positive. Most of the tests were influenced by sex and by age.

VARIOUS laboratory tests have been proposed to indicate inflammation, especially the inflammation associated with infection. Probably the oldest of these is the erythrocyte sedimentation rate.[1] It is well known that this is a sensitive test and is influenced by pregnancy, anemia and dysglobulinemia. The sedimentation rate is a reflection of increased levels of plasma fibrinogen, gamma globulin and other asymmetric macromolecules. The test is frequently used to monitor the inflammatory state associated with chronic disease such as rheumatoid arthritis and tuberculosis.

The nitroblue tetrazolium test has been advocated to help diagnose bacterial infections in vivo. However, studies of this test in such diverse conditions as myocardial infarction, vaccination, hemophilia with hemorrhage and thromboembolic phenomena have shown that positive tests may occur in inflammatory states unassociated with infection.[2]

C-reactive protein is a serum β-globulin which reacts with the C polysaccharide of the pneumococcus in the presence of calcium ions. It appears to be a response of the liver to products of inflammation and appears in the blood at times of infection or tissue necrosis. It is widely used as an inflammatory index in rheumatic fever.[3,4]

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More recently, the antiglobulin antibodies called rheumatoid factors once thought to be solely associated with rheumatoid arthritis have been demonstrated in bacterial endocarditis and other diverse states of disease in severely ill patients.[5,6] The anti-Fab antibodies, an unrelated group of antiglobulin antibodies called serum agglutinators, are rarely demonstrable in high titer in diseases other than those associated with severe suppurative infection.[7] Although it has not been unequivocally established that these antiglobulins are true antibodies, nevertheless they are expressions of a complex mechanism involving both inflammation and immunity.

For editorial comment, see page 601.

Despite many studies on these tests individually, no study has been performed on a group of patients testing for all five of these indices of inflammation. This study of these five tests on 236 persons was undertaken to correlate the reactions of the tests with each other and with the associated diseases.

MATERIALS AND METHODS

Patient Selection

A total of 236 persons was studied, 101 males and 135 females; 113 were white, and 123 were black.

Serum agglutinators (anti-Fab IgG), rheumatoid factors (anti-Fc IgG), erythrocyte sedimentation rate, nitroblue tetrazolium test and C-reactive proteins were offered to any physician who wished to use the tests as aids in evaluating any undiagnosed patient with possible covert infection or to aid in determining effectiveness of treatment in those patients having already

diagnosed infections. In addition, these tests were made available for evaluation of other patients where the attending physician deemed them of value. Technical personnel provided the "normal" blood samples.

Thus, patient selection reflected the interest of the clinicians, and some of the patients presented diagnostic dilemmas.

The persons were divided into nine groups. Group 1 comprised 34 hospital personnel who denied any disease. Group 2, localized lesions, was subdivided into infection, atopic dermatitis and aphthous ulcers. Group 3, systemic infection, was represented by septicemia, endocarditis, viral and fungal infections. Group 4, postinfection, represents a group of patients with systemic fungal infections who had been treated, released and were being followed (up to five years) after the initial diagnosis. Group 5, metabolic disease, presented sometimes as two or more diseases, such as diabetes and furunculosis, or hypothyroidism and urinary tract infection. Unless the infection was substantial, the patient was listed under the basic disease process. Many of the patients had chronic alcoholism. Group 6, rheumatic fever; Group 7, rheumatoid arthritis; Group 8, systemic lupus erythematosus (SLE); and Group 9, posttransplantation.

Preparation of Fab Fragments of the Ripley Anti-Rh Antibody

This serum was used for the preparation of the enzyme digested fragments of IgG globulins. The globulin fraction of the anti-Rh serum was obtained by 47% $(NH_4)_2SO_4$ precipitation. The precipitate was taken up in 0.15 M NaCl solution and dialyzed in 0.02 M phosphate buffer, pH 7.8, and applied to a column of DEAE cellulose (Carl Schleicher and Schuell Co.) equilibrated with the same buffer. The first peak obtained with the starting buffer was isolated and dialyzed against the specific buffer used for digestion.

Methods of Hydrolysis

Methods for the hydrolysis of the anti-Rh antibodies of the Ripley serum with selected proteolytic enzymes have been described in detail elsewhere.[8,9]

Four proteolytic enzymes were selected. All were used at 1% of the weight of the protein. Papain digestion was performed at pH 7.4 with 0.1 M phosphate buffer in the presence of 0.01 M cysteine and 0.002 M ethylene-diamine-tetraacetate (EDTA), subtilisin at pH 7.5 with 0.025 M Tris (hydroxymethyl) aminomethane buffer containing 0.1 M NaCl in the presence of 0.01 M cysteine; trypsin at pH 8.1 in 0.05 M Tris buffer containing 0.01 M $CaCl_2$ in the presence of 0.01 M cysteine; and chymotrypsin at pH 7.8 in 0.08 M Tris buffer containing 0.1 M $CaCl_2$ in the presence of 0.01 M cysteine. A second addition of an equal amount of trypsin or chymotrypsin, added after four hours of digestion, was found to be necessary to achieve complete digestion by these enzymes. The digestions were performed at 37°C for 18 hours and were stopped by adding one volume of 1.25 gm per 100 ml N-ethylmaleimide to nine volumes of the protein solution, followed by dialysis against 0.15 M NaCl solution. The four digest preparations were used to sensitize the erythrocytes.

Standardization and reproducibility of the tests were achieved by using uniform procedures, Rh-positive erythrocytes from a constant source and anti-Rh antibodies from a single source. A human serum with high titers of these serum agglutinators was used as a control.

Methods of Testing

Test for serum agglutinators: Serum specimens were tested for the following serum agglutinators: papain, subtilisin, trypsin and chymotrypsin. A test for serum agglutinators was considered positive if three of these four tests were positive with a titer of 160 or above. Methods for performing these antiglobulin tests have been reported in detail elsewhere.[10]

Test for rheumatoid factor: The presence of rheumatoid factors was determined by using the sensitized human cell test (SHC). Methods for determining rheumatoid factors with the SHC have been described elsewhere.[11] A test for rheumatoid factors was considered positive if the titer was 20 or above by the sensitized human cell test.

Erythrocyte sedimentation rate (ESR): The Westergren method was used to document the erythrocyte sedimentation rate. The fall of the erythrocytes in millimeters in one hour was noted. The normal sedimentation rate with this method is 0 to 15 mm for men with an average of 4 mm and 0 to 20 mm for women with an average of 5 mm.[12]

Nitroblue-tetrazolium test (NBT): The NBT test was performed according to the modified method of Dorwick (1972) on venous blood collected in 4.5 ml vacutainers containing 3.8% sodium citrate. The NBT test was performed as soon as possible after the blood was drawn in order to eliminate morphological changes caused by prolonged exposure to the anticoagulant.

A standard solution of 0.4% NBT was prepared in a 10 ml stoppered volumetric flask by dissolving 20 mg of nitroblue tetrazolium (Grade III reagent N6876, Sigma Chemical Co., St. Louis MO) in 5 ml of sterile 0.85% isotonic saline. To dissolve the NBT, the stoppered flask was swirled under hot, running tap water until the solution became clear. This solution was then

filtered and transferred to a brown bottle and stored at 4°C. The solution was stable for 72 hours.

Piromen (pseudomonas polysaccharide) obtained from Travenol Laboratories, Inc., Morton Grove IL, was used in the preparation of a positive control. Two tubes were labeled with the patient's name, one tube designated "control" and the other, "test"; 0.2 ml of citrated blood and 0.05 ml of Piromen (50 mg/ml) was added to the control tube. This tube was capped and the mixture was incubated in a water bath for 10 minutes at 37°C. After the "control" tube had been incubated for 10 minutes, the "test" specimen was prepared, and 0.2 ml of citrated blood was placed in the "test" tube. To both tubes, 0.1 ml of 0.4% NBT was added. The tubes were mixed by gently shaking, capped and incubated in a water bath at 37°C for 30 minutes.

The tubes were removed from the water bath, and one drop of the blood-NBT "test" mixture was added to two precleaned, labeled glass slides. Special care was taken to avoid damage to the white blood cells. The same procedure was used to make the "control" slides. The slides were air dried and stained with Wright's stain. The stained slides were examined microscopically using an oil immersion lens, and 100 neutrophils were counted. Neutrophils were classified as "NBT positive" if they contained any visible formazan deposits. Cells that were disrupted or clumped together were not counted. The per cent of NBT-positive neutrophils was reported as 0-15% normal and 16-100% abnormal.

C-reactive protein (CRP): The CRP was performed using the Organon CRP Dri-Dot qualitative test according to the methods of Organon Diagnostics, West Orange NJ. Thus, 0.03 ml of serum was applied to the Dri-Dot slide near the CRP latex reagent, and 0.03 ml of distilled water was applied to the slide in the same manner. The distilled water and the latex reagent were blended until homogenous and then thoroughly mixed with the serum. The slide was gently tilted for one minute, and the reactions were read. A positive result was macroscopic agglutination of the latex, and a negative result was no visible agglutination of the latex reagent.

RESULTS

The *erythrocyte sedimentation rate* is probably the most popular humoral indicator of inflammation, especially for monitoring chronic disease. Among the 236 persons tested, we do not find any group, not even the normals, where the test is invariably negative.

Table I gives the number of persons with positive tests in each group. In Group 1, we find 34 normal persons among whom there were no positive tests for rheumatoid factors, serum agglutinators or CRP. However, two of these persons, a 40-year-old white male and 30-year-old black female, had positive NBT tests, with values of 20% and 16% respectively. The ESR of the male was only three while that of the female was 15. These persons denied disease. In addition, four of 16 normal females had an ESR greater than 20 mm/hr while none of the 18 males had positive tests. We were not able to associate these rapid rates with disease or the use of birth control pills.

Among the 44 patients (Group 2) with localized lesions, all of the patients with infections showed positive tests. However, among the patients with atopic dermatitis and aphthous ulcers, the modest increases in the sedimentation rates were largely confined to females.

Eighteen patients (Group 3) had systemic infections and only one patient, an 87-year-old male patient with gram negative sepsis, had a normal ESR. It is of interest that this patient had an elevated NBT test and a positive test for CRP.

Ten ambulatory patients (Group 4) were being followed for postfungal infections such as cryptococcosis and blastomycosis. The two who were still culture positive showed a high ESR. Of the remaining eight culture-negative patients, five showed modest increases in their ESR (16 to 30).

Among the patients with metabolic disease (Group 5), factors affecting the ESR are prominent, and we find that 80% of these patients gave positive tests.

Of the 20 patients with rheumatic fever (Group 6), ten gave a negative ESR. Most of these patients were attending a followup clinic, and their primary attack had occurred one to three years previously. Likewise, the seven patients in Group 7 (rheumatoid arthritis) who did not give a positive ESR were ambulatory patients attending the arthritis clinic. All but one patient with SLE (Group 8) had a positive ESR.

The *nitroblue tetrazolium test,* like the erythrocyte sedimentation rate, was found to be positive in all nine groups tested. The test is less sensitive than the ESR, but a positive test is not confined to infection. Among the patients with localized infection (Group 2), the diagnosis of those with negative NBT tests were septic arthritis (1), sickle cell anemia with infection (1), decubitus ulcer (1), furunculosis (1) and appendicitis (1).

Of the 14 patients studied with aphthous ulcers, the six patients with positive NBT tests (20%-40%) were all adult members of one family. The eight unrelated adults with aphthous ulcers gave negative tests. Two of the adolescents with atopic dermatitis gave positive NBT tests. The only patient with systemic infection who gave a negative NBT test had infectious mononucleosis.

Among the patients with metabolic disease (Group 5), the patients with alcoholism were most likely to

Table I. Number of tests positive for infection or inflammation as measured by five different tests on each of 236 persons

Diagnoses	Total	Erythrocyte Sedimentation Rate	Nitroblue Tetrazolium Test	C-Reactive Protein	Rheumatoid Factor	Serum Agglutinators
Normals	34	4	2	0	0	0
Localized lesions:						
Infections	19	19	14	9	1	3
Atopic dermatitis	11	4	2	2	0	0
Aphthous ulcers	14	4	6	4	1	0
Systemic infection	18	17	17	10	4	4
Post-fungal infection	10	7	3	0	1	0
Metabolic disease	40	32	12	8	1	0
Rheumatic fever	20	10	7	3	0	1
Rheumatoid arthritis	47	40	14	26	39	1
SLE	8	7	3	3	4	0
Post-transplantation	15	10	4	6	0	0

have a positive test. This diagnosis is apt to include overt or covert infection.

Only 35% of the patients with rheumatic fever gave positive tests. These patients with positive tests usually had active disease, but this was not invariably true.

Among the 47 patients with rheumatoid arthritis, 35 were adult-onset arthritis, seven had juvenile rheumatoid arthritis and five had rheumatoid arthritis and an infection such as wound abscess, leg ulcers, or urinary tract infection. The NBT test was much higher in juvenile rheumatoid arthritis and adult arthritis with infection than it was with adult rheumatoid arthritis alone. Less than 15% of adult rheumatoids gave positive NBT tests; in the cases in which the test was positive, it rarely exceeded 20%.

Patients with SLE (Group 8) may also show positive NBT tests in the absence of infection.

C-reactive protein was measured in this study by a commercially available slide test. The test with these nine groups of persons was less sensitive than the ESR or the NBT test. Neither patients with postfungal infection nor normal persons gave positive tests, while about 55% of patients with systemic infections gave positive tests. Among the patients who gave negative tests were two with infectious mononucleosis, one with toxoplasmosis and others with gram negative sepsis.

Among the 14 patients with aphthous ulcers, four gave positive CRP tests. Three of these four persons were members of the same family, which showed the high incidence of positive NBT tests. The other person was a friend of the family.

The presence of positive tests for CRP in rheumatoid arthritis could not be related to the duration or severity of the disease.

Among the 236 persons tested for *rheumatoid factors*, the highest percentage of positive tests (82%) was found, as expected, in Group 7, the patients with rheumatoid arthritis. Among the eight patients with negative tests, we find that seven were juvenile rheumatoids. Thus, in adult-onset rheumatoid arthritis, we find only about 2.5% of patients will be seronegative. However, 22% of patients with systemic infections showed positive tests. The patients with positive tests had subacute bacterial endocarditis (1), septicemia (1), abdominal abscess (1) and Rocky Mountain spotted fever (1). Patients with systemic lupus erythematosus showed positive tests in 50% of patients.

Tests for rheumatoid factors were negative in atopic dermatitis, rheumatic fever, posttransplantation and normals. Titers of 160 or above were found in infection

abdominal abscess), metabolic disease (chronic heart failure), systemic lupus and rheumatoid arthritis. The highest titers were found in rheumatoid arthritis and the next highest in SLE as expected.

The tests for *serum agglutinators* (anti-Fab IgG) are usually found to be positive in patients with severe suppurative infection. This is the least sensitive of all the tests and positive tests are almost always confined to patients with significant gram positive infection. Infections associated with gram negative organisms, or viruses, or characterized by granulomas, usually do not show high titers of these antibodies. Only eight of the 236 persons tested (3%) showed positive tests. As anticipated, most of these positive tests were associated with infection. Among the three patients with localized infection who showed positive tests, we find renal failure and septic arthritis (1), infected subdural hematoma (1) and thigh abscess (1). Among the patients in Group 3, systemic infection, positive tests were found in patients with endocarditis (2) and staphylococcal septicemia (2). Unexpectedly, one patient with rheumatic fever gave a positive test. This patient had active rheumatic fever with a significant degree of carditis. The patient with rheumatoid arthritis with a positive test had a wound abscess following abdominal surgery. This patient also gave positive ESR, NBT, and CRP tests.

The 15 patients in the (5-10 year) post-transplantation Group 9 were included to attempt to detect the influence of immunosuppression (prednisone and imuran) on the tests commonly used as indicators of infection and inflammation. Two-thirds of these patients showed increased rates of ESR. About one-quarter also showed positive NBT tests. As expected, the two tests were not always concordant. For example, one patient had an ESR of 9 and an NBT 23%, while another had an ESR of 29 and an NBT of 3%. Clinical review of the patients with positive NBT tests did not reveal overt infection. Although 40% of these patients gave positive CRP tests, once again the positive tests could not be correlated with infection.

When the immunosuppressed posttransplantation patients (Group 9) were compared with the patients in a nonimmunosuppressed postinfection state (Group 4), we find that the test for CRP was positive in 40% of Group 9 but was not positive in Group 4. The degree of reactivity of the other tests was similar.

As expected, the ESR and the NBT tests are more easily influenced by metabolic disease and localized lesions than are the other tests.

Figure 1 shows the correlation between the various tests. The positivity of the tests for rheumatoid factors, CRP and NBT is compared with the ESR arranged from left to right with an increasing degree of positivity. With negative tests for the ESR, we note that there are far less positive tests for rheumatoid factors, CRP and NBT than negative tests, and the slope of the line connecting the percentage of negative and positive tests declines to the right. The opposite is seen when we compare the percentage of negative and positive tests for rheumatoid factors, CRP and NBT with a high ESR. Now the slope of the line is ascending in all tests. Thus, with very high values with the ESR, the percentage of positive tests exceeds the percentage of negative tests. It can also be seen that the group of patients with a modestly elevated ESR does not show a strong correlation of positivity with the other tests performed.

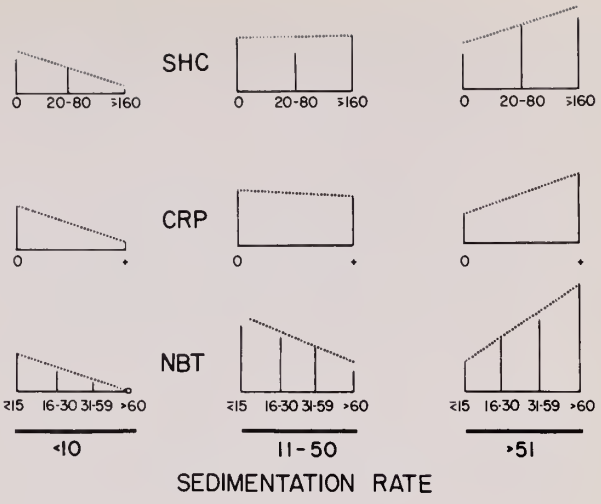


Figure 1.

Figure 2 shows the influence of sex on the percentage of positive tests. The well-documented influence of sex on the percentage of positive tests for rheumatoid factors and ESR needs no comment. However, it is appar-

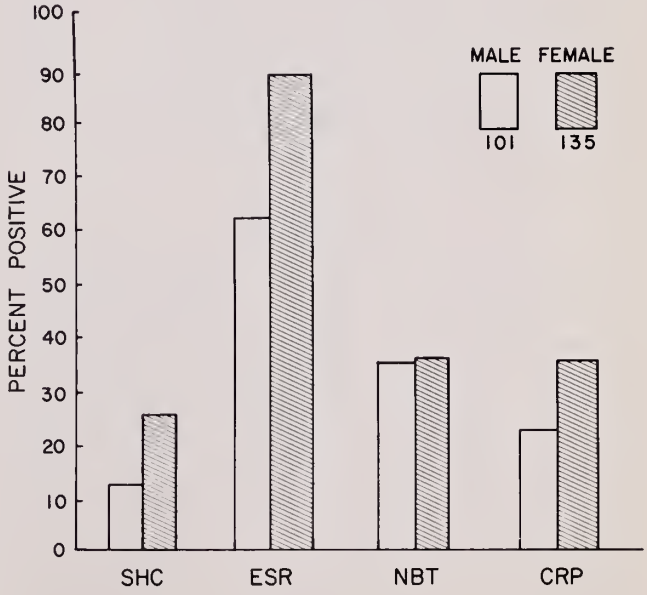


Figure 2.

ent that sex does play a role in the percentage of positive CRP tests but not the tests for NBT. It is of interest that the percentage of positive tests for CRP is not influenced in our study by sex during the first decade of life (ages 9-19). There was no apparent influence of race on these tests.

The influence of age on these tests is shown in Figure 3. The age in decades appears along the bottom line and the total persons are recorded in each group. The percentage of positive tests for each group is shown for

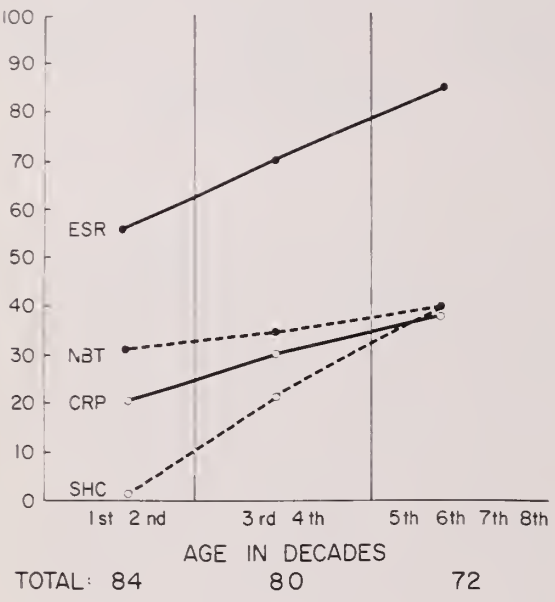


Figure 3.

each of the three age categories. Once again, as with sex, the marked influence of age on both the ESR and tests for rheumatoid factors is noted. Both of these values are no doubt influenced by the relatively large number of patients with rheumatoid arthritis in this study (19%). However, the tests for NBT and CRP also show an ascending slope with age.

DISCUSSION

These studies of the correlation of five different tests for inflammation showed that when any of the tests were strongly positive there was an increase in the incidence of positivity of the other tests. There are, however, individual and startling exceptions. One patient with the diagnosis of active rheumatic fever showed a modest ESR of 26 but an NBT test of 62%, and although his serum agglutinators were positive, his test for CRP was negative.

The association between CRP and ESR tests has been reported. Rozansky and Davis (1958) found that the CRP was observed in 15% of blood samples that showed a normal ESR, but that this percentage rose to 73% when the ESR showed an increased value. We found that this concordance depended upon the group of persons studied. Among the normals, all of the persons with increased ESR had negative NBT tests, while among the patients with elevated ESR with metabolic disease or rheumatoid arthritis, approximately 56% had positive CRP tests. Other CRP reagents that are very sensitive to these globulins will give a higher percentage of positive tests in sick patients but also a higher percentage of positive tests in normals.

It is of interest that six adult members of one family had aphthous ulcers and positive NBT tests while eight unrelated adults with this mouth lesion had negative NBT tests. In addition, the 50% incidence of positive CRP tests in this family suggests an infection. However, this family had no overt signs or symptoms of a systemic infection.

There was an influence of sex but not of race on the ESR and also the CRP. The well known but poorly understood female predisposition to rheumatoid arthritis accounts for the association of positive tests for rheumatoid factors and females. No attempt was made to correlate positive tests for serum agglutinators because only nine of 236 persons showed positive tests. Positive tests for these antiglobulins are uncommon and are associated with severe suppurative infection.

The correlation of positive tests (ESR, CRP, SHC and NBT) with increasing age was unexpected. It is true that infection complicating a connective tissue disease or metabolic disease is more common in the aged than in the young. It is of interest that rheumatoid factors are uncommonly present in the young even when the disease with which they are most closely associated is present. There is no known association between increasing age and the presence of serum agglutinators.

The suppressive effect of the corticosteroids on these tests is poorly understood. It is startling to realize that these drugs were used in about 50% of the persons in this study. Numerous studies of the suppressive effect of these drugs on the NBT test have been reported.[13,14,15] Contrariwise, these drugs have no substantial effect on titers of rheumatoid factors. The influence of these drugs on the ESR and CRP is essentially unknown. We found no substantial influence of these drugs on these tests in the posttransplant patients. However, it is difficult to evaluate inflammation and the influence of the antihomograft responses under these circumstances.

It might be argued that the antiglobulins are not truly tests of inflammation; they were included in this study because their presence in serum is almost invariably associated with other indices of inflammation. Rheumatoid factors in high titer are found in rheumatoid arthritis, and the titer correlates well with severe

and persistent disease. Nevertheless, high titers may be found in patients who are severely ill with a variety of disease states. Probably the best association is with subacute bacterial endocarditis. Rheumatoid factors in nonrheumatoid states are usually associated with positive tests for NBT.

Because of the influence of sex and age on some of these tests and the fact that when strongly positive there is an increased correlation with positivity in other indices of inflammation, it must be stressed that these tests should in no way be used to alter a diagnostic impression made on the basis of clinical signs and symptoms. To date there have been no laboratory tests without false positive and false negative findings.

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(Additional references on request.)

Microlumbar Discectomy

By Harold J. Goald, MD, *Arlington, Virginia*

A microsurgical procedure for the treatment of herniated lumbar disc is described and the author recommends its use instead of the standard laminectomy.

MICROLUMBAR discectomy is a new and better approach to the surgical treatment of herniated lumbar disc. Special instruments and the surgical microscope, with its high magnification lenses and high intensity light source, make it possible to remove a herniated nucleus pulposus through a one-inch skin incision without the removal of any portion of the lamina or facet.

Microlumbar discectomy was developed by Dr. Robert Williams of Las Vegas, Nevada, in 1972. His results were reported to the American Association of Neurological Surgeons in April, 1975. The operation is performed by the surgeon using the surgical microscope, with a nurse assistant. It is totally a microsurgical procedure. There is no laminectomy or curettement of the disc space.

The Operation

A one-inch skin incision is precisely centered over the interspace to be explored. A unilateral subperiosteal reflection of muscle and fascia is carried out. At 25 magnification, the ligamentum flavum is removed with a 1-mm Kerrison rongeur. The nerve root is identified and retracted. All structures are greatly magnified, and small tears in the annulus from which very tiny free disc fragments extrude can easily be spotted. The annulus is pierced with a blunt dissector, and a blunt hook and curette are used to loosen disc fragments. The disc material is removed with a micropituitary cup forceps, having a 1-mm jaw. The nerve root is fully visualized at all times. The epidural veins are clearly seen and avoided, so that blood loss is less than 50 cc. The fascia, subcutaneous tissue, and skin are closed in layers. The operation takes about 45 minutes.

Postoperatively, the patients experience little pain because of the small incision and minimal disruption of soft tissue. The patient is walked at the bedside the night of surgery and is almost always discharged from the hospital by the fourth postoperative day. Some patients are discharged sooner.

Results

In a series of over 300 patients without previous lumbar surgery operated on and followed by Dr. Williams since 1972, there have been only three recurrences of disc herniation. They were caused by unusual stress to the disc during the immediate postoperative period.

In this author's series of 72 patients operated on over the last 14 months using this technique, there has been no recurrence of disc herniation. All patients but five have returned to their previous activities, and they appear quite comfortable in comparison with their preoperative discomfort and disability. Job retraining for lighter work has been utilized for these five patients.

The decision to operate in the author's patients was based in all cases on the presence of intractable back and sciatic pain unrelieved by adequate trials of rest and pelvic traction as well as physical therapy. The reflex changes, sensory alteration and focal weakness in the lower extremity were correlated with a lumbar myelogram which was positive for a filling defect in 90% of these patients.

In the author's series of cases, there has been no wound infection or nerve root injury. In Dr. Williams'

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series, the rate of recurrence was well below that reported by others.[1,2] Injury to a viscus or major blood vessel has never occurred. Since no portion of the spine is removed, early ambulation poses no additional stress to these structures. The patients are pleased with their ability to ambulate quickly and with the small amount of postoperative pain.

Conclusion

After 15 years of experience in using the standard laminectomy, the author finds this new procedure a much better operation for these reasons: there is less surgical trauma and less blood loss during the operation; postoperatively, the patient has less pain and ambulates sooner; the patient's hospital stay is shortened by five to six days. The cases here reported confirm the results obtained by Dr. Williams.

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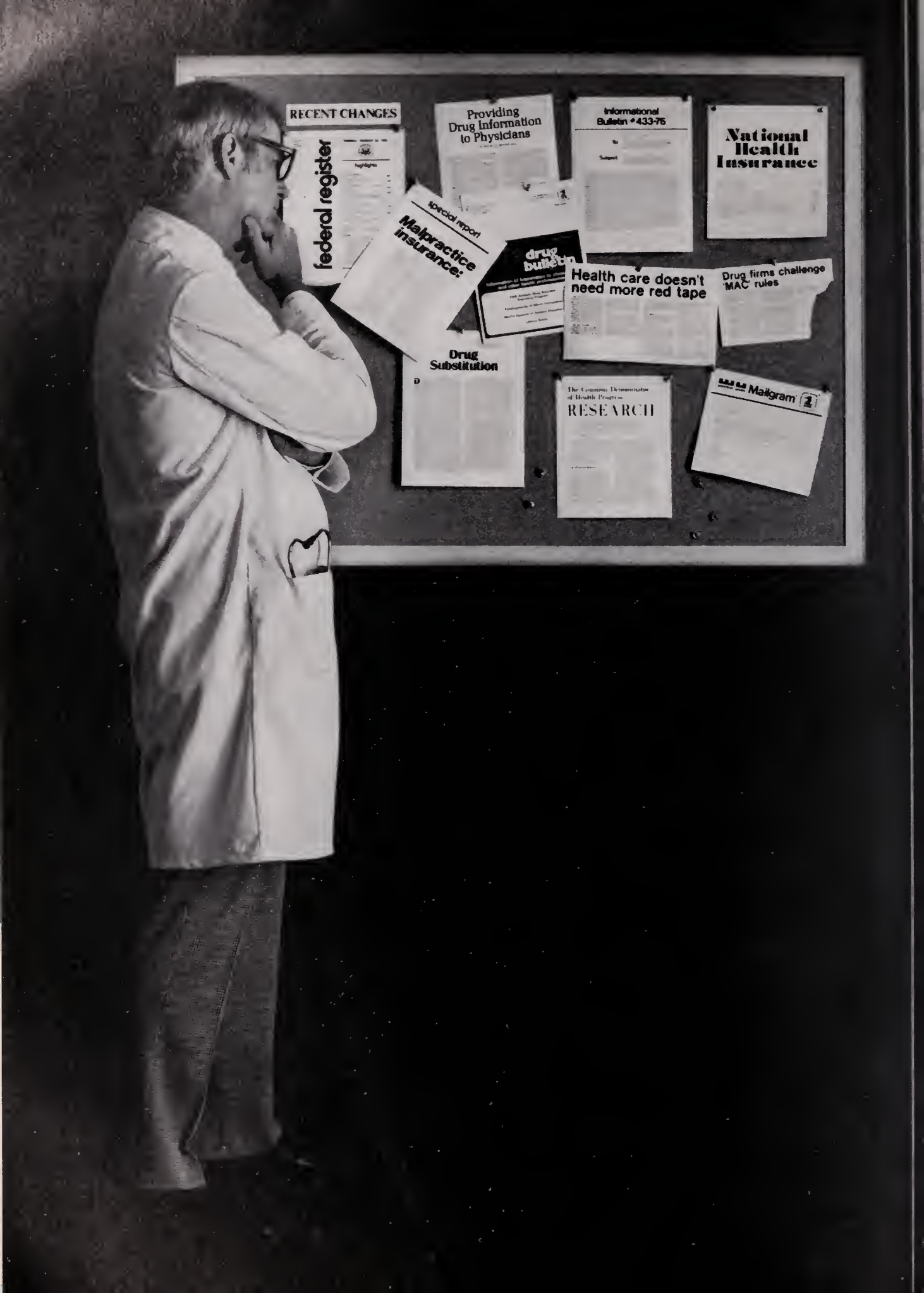
The Zeiss surgical microscope used by the author.



Disc fragments removed by microlumbar discectomy.



A nicely healing one-inch incision.


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Pulmonary Rehabilitation

By Emil J. Kleinholz, MD, and Pam Bryson, RN, *Richmond, Virginia*

Significant improvement was shown by all ten COLD patients who completed a course in supervised exercise. The authors strongly endorse the described rehabilitation program.

THE devastating effects of chronic obstructive lung disease (COLD) cannot be altered by any form of therapy. Progressive dyspnea begets progressive inactivity until many patients are confined to a bed-and-chair existence. In recent years studies have shown that comprehensive programs of rehabilitation emphasizing exercise training can ameliorate the course of COLD.[1-3] While increase in the quantity of life cannot be substantiated, increased quality of life has been clearly documented.[4]

This report documents the first year's experience of the Pulmonary Rehabilitation Program at the Wirt Hatcher Memorial Cardiopulmonary Laboratory of the Retreat Hospital, Richmond.

METHODS

Patients were selected on referral of their attending physician. Any patient with COLD who was dyspneic and agreed to stop smoking was accepted into the program.

Audiovisual and printed material were used to provide patients and their families with a basic understanding of chronic obstructive lung disease.

Where applicable, patients were referred to the social services department in order to obtain needed assistance or services from governmental or other providers.

Physical therapists instructed patients in abdominal breathing and pursed lip expiration techniques.

The inhalation therapy department assisted those patients who required home IPPB units to obtain them. Instruction in giving treatments and in cleaning and maintaining the units was also provided.

Submitted 2-23-76

Exercise reconditioning was the central feature of the program. Prior to beginning exercise training, all patients underwent spirometry testing and submaximal cardiac stress testing. All exercise was carried out on a



Monitoring a patient on the treadmill.

treadmill with variable speed and incline controls. During exercise and for at least one minute following, continuous cardiac monitoring was carried out. Patients were started at 1 mph and 0% grade, and speed and grade were increased based on the patient's ability to perform. Exercise was stopped when either the patient

felt he/she could no longer continue, or 85% of maximum predicted heart rate was attained, or significant arrhythmias occurred. All patients were exercised breathing ambient air. Patients exercised biweekly for a period of 12 weeks.

After the first six weeks, patients were expected also to exercise on their own in preparation for the termination of the formal program. They were advised to walk in shopping malls that have the advantage of air conditioning in the summer and heating in the winter.

Patient achievement was calculated by "met-minutes". A "met" is a unit of resting energy expenditure. The number of mets required to walk at a given speed and grade are established. To obtain met-minutes one simply multiplies the number of minutes at a given met level. For instance, 2 mph 0% grade = 2 mets. If a patient walked at this stage for five minutes, he would have performed 5 2 = 10 met-minutes.

RESULTS

Of 13 patients entering the program, ten completed the 12-week course. There were six males and four females with an average age of 60 and an age range of 53 to 74 years. Only one patient continued to smoke. One-half (three males and two females) of the group had a history of heart disease. Bronchodilators were taken regularly by nine and steroids by three patients.

TABLE I

WORK ACCOMPLISHED
(in met-minutes)

PATIENT	START	END	MAXIMUM
A.F.	16	29.2	51.6
G.T.	12.2	60	60
V.C.	16	40	68.2
G.L.	59.2	136	136
A.C.	19.2	108	108
R.L.	65.2	116	116
M.W.	33.5	47.2	70.2
J.B.	5.2	60	80
E.L.	8.2	31.2	49.2
J.M.	31.2	74	109.2
Average	26.59	70.16	83.84
Improvement		102%	215%

All patients showed objective improvement in exercise performance (Table I). The "end" figures are the patient performances on the last day of the program and, as shown by the "maximum" column, do not adequately reflect the individual patient's exercise capability. However, if one takes only this "end" data, there was an objective improvement of 102%.

As expected, spirometric evaluation before and after the program showed no significant change.

Subjectively, all patients felt improved after completion of the program. There was a generalized sense of well being in addition to being less dyspneic. On questioning, five felt "greatly improved", three "moderately improved" and two "mildly improved".

DISCUSSION

The results obtained by the ten patients described reflects the experience at various university centers throughout the nation.[1-4] A comprehensive program of rehabilitation for patients with COLD can provide significant subjective and objective improvement.

The single most important aspect of these multi-faceted programs is exercise. Simply stated, exercise improves muscular efficiency so that oxygen requirements are diminished, thereby allowing more work to be performed.

We feel strongly that any patient with COLD who is short of breath during routine activity should be entered in a rehabilitation program. It is hoped that early referral of patients will allow many of them to continue gainful employment.

The materials for exercise rehabilitation are not prohibitively expensive, and this form of therapy should be available at all hospitals treating large numbers of patients with COLD.

Acknowledgement

The authors thank the family of Wirt Hatcher, without whom this program would never have existed, and J. VanBrackle, Administrator, Retreat Hospital, for his interest and help.

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Arteriosclerotic Skin Lesions Resembling Cutaneous Vasculitis

By Kenneth E. Greer, MD, and
Paul I. Schneiderman, MD.
Charlottesville, Virginia

The cutaneous lesions of arterial occlusive disease, whether they result from arteriosclerosis, vasospastic disorders or cutaneous vasculitis, are usually due to the effects of tissue ischemia. The changes are variable and not entirely specific for any one type of vessel disease. We report two nondiabetic patients with unilateral lesions of the calf which had been diagnosed as cutaneous vasculitis. Further evaluation revealed that both patients had severe arteriosclerosis of the lower extremities, and the skin lesions improved after surgical correction of the occlusive vascular disease.

CASE REPORTS

Case 1. A 52-year-old woman was referred in July, 1974, for evaluation of skin lesions of the posterior calf. The cutaneous eruption had begun six months previously as tender erythematous plaques which did not improve with topical corticosteroid therapy. A biopsy, which had been done elsewhere, was reported as showing "mild chronic dermatitis or vasculitis". At the time of her first clinic visit, a tentative diagnosis of cutaneous vasculitis or panniculitis was made, based on the clinical appearance of the lesions (poorly demarcated, erythematous and infiltrated plaques on the left posterior calf with mild livedo reticularis) and the previous biopsy report. No additional biopsies were done, but pertinent laboratory studies included a normal glucose tolerance test, elevated erythrocyte sedimentation rate (76 mm/hr), negative ANF and cryoglobulins, and normal serum cholesterol and triglycerides. A roentgenogram of the chest was normal, but the patient had a markedly positive reaction to an intermediate PPD skin test. She was placed on isoniazid, 300 mgm daily, for possible erythema induratum, but there was no improvement in the skin lesions in six weeks.

In August, 1974, the patient was admitted to the hospital for arteriography after surgical consultation suggested that the cutaneous changes possibly were related to vascular insufficiency of the lower extremity. The patient had been a heavy cigarette smoker for 30 years, hypertensive for at least two years, and gave a history of pain in both legs, initially only with exercise but more recently at rest. She had no history suggestive of cerebral or coronary vascular disease.

Physical examination at the time of admission revealed an obese woman with a blood pressure of 170/106 mm Hg, nonpalpable pulses distal to femoral pulses, which were barely palpable, and skin lesions of the left posterior calf. The skin of the left calf was shiny, faintly erythematous and atrophic, with several small crusted and scaly areas (Figure 1). The calf was tender but not cold or cyanotic. Both feet blanched with elevation for one minute, and there was moderate dependent rubor of the left foot.

An abdominal aortogram revealed severe arteriosclerotic changes of both iliac vessels with an atheromatous plaque of the left femoral artery and arteriosclerosis of both superficial femoral arteries with 80-90% stenosis (Figure 2). The patient had a left femoral-popliteal by-pass graft insertion using the saphenous vein from her left leg. Postoperatively the skin lesions improved, but her course was complicated by breakdown and infection of the sites of surgical incision, and clotting of the vein graft, requiring resection of the graft and reconstruction using 8 mm Dacron prosthesis and, three months later, amputation of the left leg due to gangrene.

Case 2. A 57-year-old woman developed painful erythematous skin lesions of the left calf in July, 1975. Within one week the lesions had spread to the left thigh and ankle. Her physician made a tentative diagnosis of cutaneous or possibly systemic vasculitis and referred her to the dermatology clinic for consultation the same day. On examination there were scattered, dusky red, tender, infiltrated plaques on the left calf and ankle with no ulcers or nodules (Figure 3). In addition, there were mild changes suggestive of livedo reticularis above the left knee. The cutaneous lesions were remarkably similar to the early changes described in Case 1. When it was noted that the peripheral pulses were diminished, the diagnosis of arteriosclerotic vascular disease was suggested, and the patient was admitted to the hospital for arteriography. She had a history of intermittent claudication but no pain in the legs at rest. She had no past history of hypertension, but she had been a heavy cigarette smoker for 35 years. In addition to the cutaneous lesions of the left calf, examination on admission revealed a blood pressure of 160/100 mm Hg. The left femoral pulse was barely palpable, and the left popliteal, dorsalis pedis and posterior tibial pulses were nonpalpable. The skin of both legs was smooth, dry, slightly atrophic with diminished hair, but there were no dystrophic changes of the nails. The serum glucose, cholesterol, and triglycerides were normal. The abdominal arteriogram revealed near complete occlusion of the distal left common iliac artery (Figure 4). The patient had an aortoiliac

From the Department of Dermatology, University of Virginia School of Medicine, Charlottesville VA 22901.

Submitted 9-29-75.



Fig. 1 (left). Atrophic and shiny skin of the calf with focal scaly and crusted patches. Fig. 2 (below). Arteriosclerosis of both superficial femoral arteries with marked stenosis.



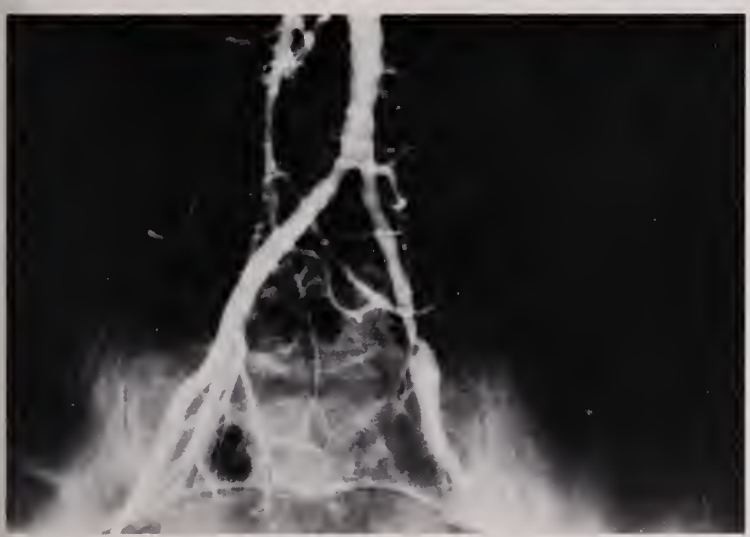
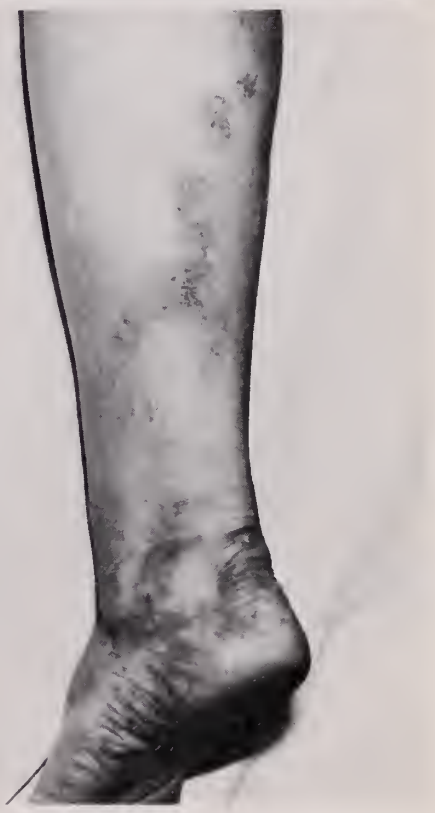


Fig. 3 (right). Dusky erythematous areas on the posterior calf and left ankle. Fig. 4 (above). Arteriosclerosis with partial occlusion of the left common iliac artery.



endarterectomy with removal of an atheromatous plaque and thrombus from the left common iliac artery. The peripheral pulses were excellent postoperatively and the cutaneous lesions healed completely within two weeks.

DISCUSSION

The most common cause of peripheral vascular disease of the lower extremity is arteriosclerosis. Atheromatous plaques, thrombi and embolic material produce vessel occlusion with variable clinical signs and symptoms depending upon the size and location of the vessel involved, collateral circulation and whether or not the occlusion occurs acutely or chronically. In an acute process, such as occurs in atheroembolism, there may be the sudden development of pain and numbness of the limb associated with dusky erythema or livedo reticularis. There may be progression to ulceration and gangrene, especially of the foot and toes, but occasionally of the ankle and calf.[1] Occasionally unusual cutaneous changes resembling polyarteritis nodosa or cutaneous vasculitis occur with atheroembolism.[2,3] These changes may include tender plaques or nodules (often violaceous in color), petechiae, livedo reticularis and occasionally focal ulceration.

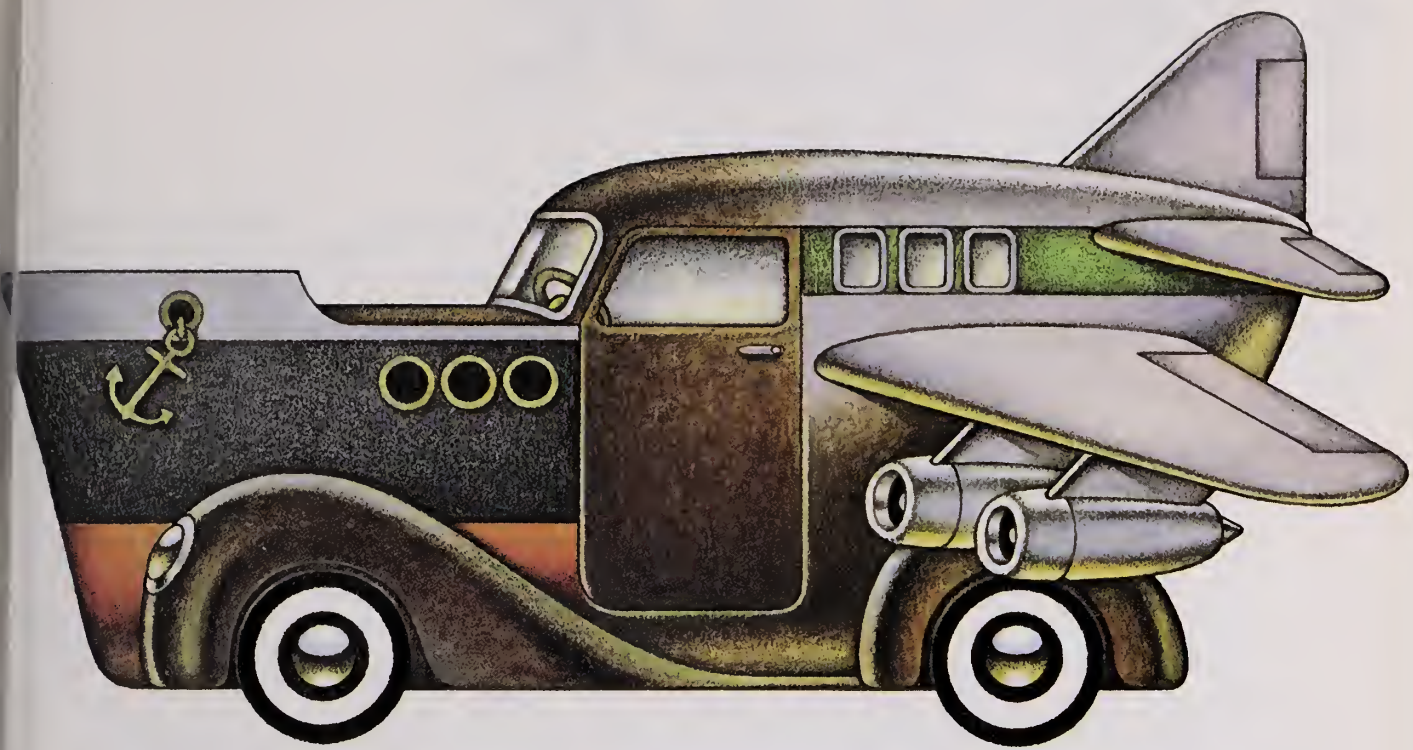
Patients with chronic arteriosclerotic peripheral vascular disease frequently give a history of intermittent claudication or, occasionally, pain in the legs at rest, especially when the disease is more severe. The cutaneous lesions associated with chronic vascular occlusive disease of the lower extremities include dry, scaly and atrophic skin with loss of hair on the limbs and occasionally dystrophic changes of the nails.[4] The patients reported here had severe arteriosclerotic disease of the legs demonstrable radiographically. However, both patients were originally diagnosed as having cutaneous vasculitis on the basis of unilateral skin lesions of the calf. The diagnosis of cutaneous vasculitis was suggested by the fact that the lesions were focal, tender, erythematous and slightly infiltrated, and there were mild changes characteristic of livedo reticularis surrounding the plaques. The eruption in cutaneous vasculitis, however, is very variable and can include many different types of lesions, such as erythema, urticaria, papules or nodules, vesicles, purpura, necrosis and ulceration.[5] Livedo reticularis may be seen with cutaneous vasculitis but is not specific and may occur with arteriosclerosis and other diseases affecting the blood vessels.[6]

The diagnosis of arteriosclerotic disease in these two patients was ultimately made on the basis of a history of intermittent claudication, diminished pulses on physical examination and demonstration of vascular occlusion roentgenographically. The diagnosis was confirmed at the time of surgery. In addition, the cutaneous lesions improved after the circulation through the major vessels was restored. Both patients were heavy cigarette smokers and hypertensive. Neither patient had clinical or chemical evidence of diabetes mellitus.

The delay in diagnosis of peripheral vascular disease in the first patient reported here may have contributed to her long and complicated course which eventually resulted in the amputation of her leg. The similarity of the cutaneous lesions in both patients helped to lead to an early diagnosis, as well as successful corrective surgery in the second patient. The diagnosis of peripheral vascular disease should be considered in patients presenting with lesions resembling cutaneous vasculitis.

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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* **Indications:** *Edema* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: **Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired.** Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency, (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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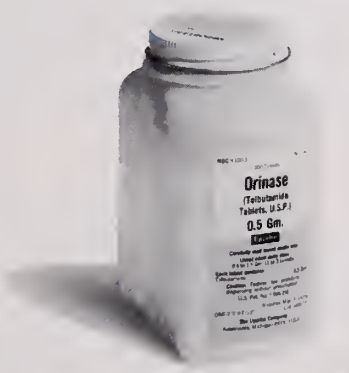
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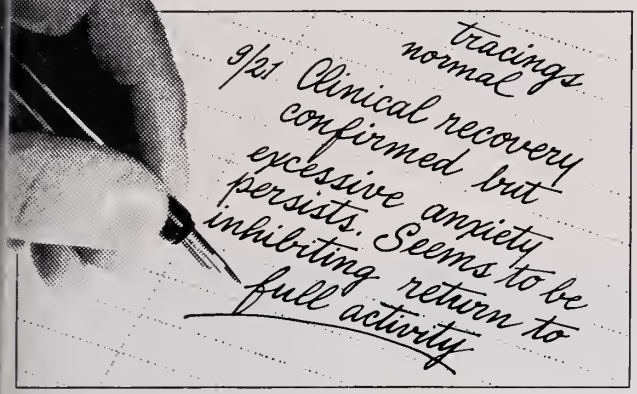
Clinical anxiety, for example, may be one reason for prolonged recuperation following cardiac healing. Yet anxiety can sometimes be beneficial in facilitating patient compliance.

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Excessive anxiety can interfere with patient management

When excessive anxiety diminishes your

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*Zohman BL: *Geriatrics* 28:110-119, Feb 1973

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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For a more detailed description of scintiphotography, see "addendum" at right.

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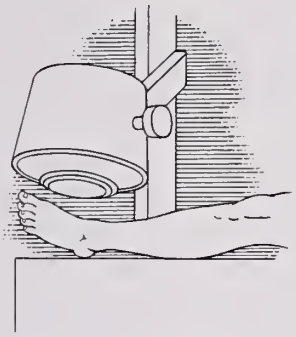
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For a brief summary of prescribing information, please see following page.

addendum

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Facts about Scintiphotography



In recent years a variety of radiopharmaceuticals have been employed to aid in the diagnosis of bone and joint disorders. The joint-imaging technique consists of injecting technetium polyphosphate intravenously, and imaging is performed with the scintillation camera two hours after the administration of the radionuclide. In general, for joint surveying, the shoulders, elbows, hands, wrists, knees, ankles, feet, and vertebral column are mapped. The entire scanning process takes approximately one hour. The criterion for a positive image is a higher concentration of radioactivity in a joint region than in adjacent nonarticular bone. In effect, each patient serves as his own control.

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and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day, without corresponding clinical benefits; 2) careful instructions to, and observations of, the individual patient are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Drug Interactions: Although INDOCIN has not influenced the hypoprothrombinemia produced by anticoagulants, patients on anticoagulant therapy should be observed closely for alterations in prothrombin time. In patients receiving probenecid, plasma levels of indomethacin are likely to be increased and a lower total daily dose of INDOCIN may produce a therapeutic effect; increases in the dose of INDOCIN should be made cautiously and in small increments.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura may occur rarely. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, a rapid fall in blood pressure resembling a shock-like state, angioedema, dyspnea, asthma, angiitis, pruritus, urticaria, skin rashes, purpura.

Ear Reactions: Hearing disturbances—deafness reported rarely; tinnitus.

Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion; coma; convulsions; peripheral neuropathy; drowsiness; lightheadedness; dizziness; syncope; headache.

Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in single-unit packages of 100 and bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in single-unit packages of 100 and bottles of 100.

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Grand Rounds: Multiple Myeloma

From the Department of Medicine of the University of Virginia School of Medicine, Charlottesville. Discussed by Charles E. Hess, MD. Edited by Robert L. Thompson, MD, and Johnson T. Carpenter, MD.

DR. EDWARD HOOK: The subject for Grand Rounds today is multiple myeloma. The patient will be presented by Dr. Thomas Delaney.

PRESENTATION OF CASE

DR. THOMAS DELANEY: This is the first University of Virginia Hospital admission for this 52-year-old white married saleswoman who was admitted for evaluation and treatment of multiple myeloma. She was in her usual state of good health until seven months prior to admission when she developed soreness in her ribs bilaterally, aggravated by inspiration which she treated with analgesics with some relief. Five months prior to admission the pain began to radiate around to the back. X-rays of the thoracolumbar spine taken three months prior to admission were reported to be normal. She was admitted to another hospital one month prior to admission for evaluation of back pain. The chest x-ray revealed compression fractures of T-10 and L-1 as well as generalized osteoporosis. A clinical diagnosis of osteoporosis was made and treatment with calcium, 750 mg daily, and vitamin D-2, 375 USP units daily, was begun. Over the next several days the serum calcium increased from the admission level of 11.9 mg/dl to 15.9 mg/dl. Calcium and vitamin D were discontinued, and the hypercalcemia was treated with hydration and corticosteroids. An intravenous pyelogram was performed three days prior to transfer to this hospital and was said to be within normal limits. The BUN and serum creatinine, which were 7 and 0.7 mg/dl respectively before the contrast study, rose to 26 and 1.8 mg/dl. Serum protein electrophoresis revealed a monoclonal gammopathy. Urinary examination for Bence Jones protein was negative. Bone marrow examination showed increased numbers of immature plasma cells consistent with the diagnosis of multiple myeloma, and consequently the patient was transferred to the University of Virginia Hospital.

Physical examination revealed the patient to be a pleasant, well-nourished middle-aged woman complaining of back and rib pain. The blood pressure was 150/90, the pulse rate 74 per minute, the temperature 36.8°C, and the respirations 20 per minute. Musculoskeletal examination revealed lower thoracic and lumbosacral tenderness. Pertinent laboratory data included a hematocrit of 36%, a white blood cell count of 10,100/mm^3 with a normal differential. The platelet count was 395,000/mm^3, ESR 63 mm/hr, the BUN 35 mg/dl, creatinine 1.4 mg/dl and calcium 11.9 mg/dl. Urinalysis was unremarkable. The serum protein electrophoresis revealed a monoclonal spike in the gamma region; serum immunoelectrophoresis revealed the monoclonal spike to be IgG (κ_2, γ_2). Urine electrophoresis was normal.

The diagnosis of multiple myeloma was confirmed. The corticosteroids were discontinued on admission, and with hydration alone the serum calcium level returned to normal by the second day. Initially, the patient was given 3000 rads to the lower thoracic and upper lumbar vertebrae. Analgesics were administered for pain, and she was fitted with a back brace in order to provide early mobilization. After two weeks she experienced a marked reduction in pain. Chemotherapy consisting of a combination of melphalan and prednisone are to be instituted after completion of radiotherapy.

Dr. Hook: Thank you very much, Dr. Delaney. Dr. Brower, could we see the x-rays, please?

Dr. Anne Brower: The chest films reveal demineralization of all the ribs. However, closer examination reveals a moth-eaten pattern more compatible with multiple myeloma than diffuse osteoporosis. The spine films demonstrate severe demineralization with compression fractures of T-10 and L-1 as previously described. Compression fractures of vertebrae can be seen with any condition that causes diffuse osteoporosis. The differential would include senile osteoporosis, hyperparathyroidism, metastatic carcinoma and multiple myeloma. The lack of involvement of the dorsal spinous processes with such extensive involvement of the vertebral body is evidence against a diagnosis of metastatic carcinoma. Multiple myeloma tends to spare the spinous processes and involve just the vertebral body. The lateral skull film reveals only two small areas of radiolucency, which are perfectly compatible with the appearance of venous lakes. However, in the absence of vascular impressions draining toward them, one cannot rule out early lytic lesions of multiple myeloma.

Dr. Hook: Thank you very much, Dr. Brower. We have asked Dr. Charles Hess of the Hematology Division to discuss his approach to the diagnosis and treatment of multiple myeloma.

DISCUSSION

Dr. Charles Hess: This patient presented with a history of bone pain, which is in fact the most frequent presenting symptom of patients with multiple myeloma. In a recent review of over 800 cases of multiple myeloma, bone pain was the initial finding in almost 70% of the patients.[1] The second most common presenting complaint was that related to bacterial infection, usually pneumonia. The other presenting symptoms included gross hemorrhage, purpura and herpes zoster infections. Although back pain is the most common presenting symptom, multiple myeloma is not a very frequent etiology of back pain. I was in general practice for five years and back pain, particularly low back pain, was a frequent complaint, yet I saw only one patient with multiple myeloma during those five years. If back pain persists, however, then the patient should have x-rays of the vertebrae.

The physical findings in multiple myeloma are characteristically nonspecific. Pallor and evidence of weight loss may be the only findings. Local swelling and tenderness on pressure over areas of lytic bone lesions are important diagnostic signs. Most of the time, however, the physical examination is not very helpful. The laboratory and roentgenographic findings, however, are striking and diagnostic.

Multiple myeloma was first reported in 1847 by Drs. McIntire and Watson, and it was at this time that Bence Jones protein was first described.[2] I would like to read an excerpt from a letter by Drs. McIntire and Watson to Dr. Bence Jones, a chemist. They had a patient, a tradesman, who presented with "mollities ossium" (soft bones). The letter reads thus: "The tube contains urine of very high specific gravity. When boiled it becomes slightly opaque. On addition of nitric acid, it effervesces, assumes a reddish hue, and becomes quite clear; but as it cools, it assumes the consistency and appearance which you see. Heat liquifies it. What is it?"[2] Dr. Bence Jones analyzed the urine and reported the "animal matter" to be a proteinaceous material, which now bears his name.

Multiple myeloma is a malignant neoplasm of plasma cells, and most evidence now indicates that it is a malignant transformation of a single clone of plasma cells.[3] It accounts for approximately 1% of malignant diseases and 10% of hematologic malignancies.[1] The death rate from multiple myeloma in the United States is about two to three deaths per 100,000 population per year. It is a disease of older people; 98% of patients are over the age of 40 years at diagnosis.[1] The peak incidence occurs in the sixth and seventh decades.

The clinical manifestations of multiple myeloma are related either to the proliferation of the malignant plasma cells in the bone marrow, to the effects of the tumor products (monoclonal immunoglobulins or subunits, i.e., Bence Jones proteins), or to abnormalities in host defense (i.e., hypogammaglobulinemia, granulocytopenia).[4]

The skeletal lesions are characteristic but not diagnostic. They usually are osteolytic but occasionally may be osteosclerotic, and they involve bones where red bone marrow exists (i.e., vertebrae, skull, ribs, pelvis). The lesions characteristically are discrete and multiple; diffuse osteoporosis without discrete lesions, however, is not an infrequent finding. The onset of symptoms related to the bone lesions is usually insidious. In some patients, particularly if a pathologic fracture has occurred, the onset of pain may be sudden and severe. With vertebral collapse, symptoms and signs related to compression of the spinal cord or nerve roots may develop and progress rapidly and necessitate immediate surgical decompression. Other manifestations of the disease also are the result of the osteolytic process. These include nausea, vomiting, polyuria, polydipsia, lethargy, confusion and coma, which usually are secondary to hypercalcemia and hypercalciuria.

Until recently, the mechanism of the bone resorption that leads to osteolysis was thought to be due to the pressure effect of the proliferating plasma cells in the bone marrow. Recent evidence, however, indicates that some malignant plasma cells secrete an osteoclast-stimulating factor which may be the mechanism of the osteolysis.[5] This finding may be the explanation for the

requent occurrence of lytic bone lesions in multiple myeloma in contrast to the unusual occurrences of bone resorption in leukemias, where the bone marrow also is heavily infiltrated with proliferating malignant cells.

The accumulation of immunoglobulins or immunoglobulin subunits (light chains and heavy chain fragments) in the plasma or urine is responsible for several clinical features of the disease. The development of the hyperviscosity syndrome depends not only on the concentration of the monoclonal immunoglobulins in the plasma but also the physico-chemical and antigenic properties of the immunoglobulin. Certain immunoglobulins have a high intrinsic viscosity or aggregation properties which lead to a hyperviscosity state at lower plasma concentrations. Some immunoglobulins reversibly precipitate or gel in the cold (cryoimmunoglobulins or cryoglobulins), and lead to a variety of symptoms and signs (i.e., purpura, acrocyanosis, gangrene of extremities). Monoclonal immunoglobulins also may coat the platelet surface and interfere with platelet function or complex with various coagulation factors (i.e., factors V, VII, VIII, prothrombin and fibrinogen) and produce serious bleeding problems.[6] Thrombocytopenia, which usually is secondary to a combination of proliferation of plasma cells in the bone marrow and chemotherapy, often potentiates these hemorrhagic abnormalities.

Infection also is a common and often serious clinical manifestation of the disease.[1,7] The infections are usually caused by encapsulated bacteria such as Streptococcus pneumoniae and Hemophilus influenzae. The increased susceptibility to infection is the result of several abnormalities in host defense. These abnormalities include a decreased level of normal immunoglobulins, impairment in the primary humoral immune response,[8] granulocytopenia (secondary to bone marrow infiltration with plasma cells or chemotherapy), and defective granulocyte function.[9] The use of immunosuppressive agents in the treatment of multiple myeloma further complicates these immune defects. Another factor that is often overlooked is the problem of immobilization, which occurs as a result of painful lytic bone lesions and pathologic fractures.

Renal insufficiency occurs during the course of multiple myeloma in approximately 50% of patients[10-12]; 30% die as a result of renal failure. Etiologic factors in the renal disease include hypercalcemia, pyelonephritis, amyloidosis, hyperviscosity syndrome, hyperuricemia, and plasma cell infiltration of the renal parenchyma.[10-12] The "myeloma kidney" is the result of mechanical obstruction of the renal tubules by precipitated Bence Jones proteins, which leads to eventual destruction of the proximal nephron. Acute renal failure has been reported following intravenous pyelography. Although the etiology is unclear, dehydration and Bence Jones proteinuria have been common denominators in most reports.[13,14] The patient today had an intravenous pyelogram performed and developed mild azotemia immediately following the procedure. Since admission, however, the serum creatinine and BUN levels have returned to normal. Intravenous pyelography should not be performed on patients with multiple myeloma unless there are clear indications and then only with adequate intravenous hydration.

The diagnosis of multiple myeloma usually is not difficult. The presence of pain, particularly radicular pain, associated with compression fractures of vertebrae and anemia in a middle-aged or elderly patient should lead one to strongly suspect the diagnosis. If a monoclonal spike is found on serum or urinary protein electrophoresis, the diagnosis is very probable. The diagnosis is usually established by finding "myeloma cells" or greatly increased numbers of both mature and immature plasma cells in the bone marrow. The "myeloma cell" is a very immature plasma cell with the nucleus usually eccentrically placed. The nuclear chromatin is finely divided and often contains several small nucleoli or a single large nucleolus. The diagnosis is more difficult when there are fewer than 20% mature plasma cells in the bone marrow. The presence of lytic bone lesions is a very important factor in such cases. The failure to demonstrate plasmacytosis in the bone marrow or an "M" spike in the serum or urine practically excludes multiple myeloma from further consideration.

Before considering the differential diagnosis of multiple myeloma, I feel it is important to review the structure of immunoglobulins and of the techniques employed to study these proteins. Advances in this area have resulted not only from studies of patients with various malignant gammopathies but also from the studies of inducible immunoglobulin-secreting plasmacytomas in certain inbred strains of mice.[3]

The basic immunoglobulin (antibody) molecule consists of two identical pairs of polypeptide chains, two light (L) chains and two heavy (H) chains, held together by disulfide bonds as well as noncovalent forces[15,16] (Figure 1). The L chains have a variable (V_L) and constant (C_L) region, as do the H chains (V_H and C_H). On the basis of antigenic differences of the H chains, five major classes of immunoglobulins are now identified: IgG (immunoglobulin G), IgA, IgM, IgD and IgE. Only two antigenic types of L chains have been identified and are referred to as kappa (κ) and lambda (λ). If a 7S IgG molecule is digested with papain, 3 fragments are produced, two Fab fragments and one Fc fragment (Figure 1). Each Fab fragment is composed of one complete L chain and the amino-terminal end of one H chain and has one antigen-binding site. The Fc fragment is composed of the carboxy-terminal end of the two H chains, and contains

the class specific antigenic determinants. Several of the biologic properties of antibodies (i.e., complement fixation) also reside on the Fc portion of the molecule. Bence Jones protein consists of dimers of either κ or λ light chains.

IgG, IgA, IgD and IgE circulate in the plasma as 7S monomers composed of two L chains and two H chains. IgM usually circulates as a 19S pentamer, and is composed of five IgM monomers and a J chain (Figure 2). J chain is a polypeptide which also is synthesized by plasma cells. Also shown schematically in Figure 2 is the structure of IgA that is found in external secretions (i.e., saliva). In addition to two IgA monomers and J chain, this "secretory" IgA also contains another polypeptide, "secretory piece," which is probably synthesized by epithelial cells.

The clinical application of various techniques that are now available to quantitate and characterize the plasma and urinary proteins has proved to be invaluable not only in early detection and diagnosis but also in the management of multiple myeloma and other malignant gammopathies. The finding of an abnormal monoclonal spike (M-spike) on a serum or urinary protein electrophoresis is the single most important laboratory abnormality in a patient suspected of having multiple myeloma. Albumin appears as a monoclonal spike in an electrophoretic pattern of normal serum (Figure 3). Serum globulins are separated into four peaks by this method, and are designated as α_1, α_2, β and γ globulins. The immunoglobulins migrate in the γ region and to a lesser extent in the β region.

Abnormal "M" spikes usually occur in the γ or β region. In Figure 4 is a serum electrophoretic pattern of a patient with multiple myeloma. The monoclonal immunoglobulin in this instance was identified as IgA by immunoelectrophoresis, a technique that permits the separation of immunoglobulins based on electrical charge, size and shape of the molecule. Through the use of appropriate antisera the class of immunoglobulin can be determined. Figure 5 represents an example of a serum and urinary electrophoretic pattern from a patient with "light chain" or "Bence Jones" myeloma. In the absence of significant renal impairment, an "M" spike usually appears only in the urine and is associated with a decrease in the concentration of normal immunoglobulins in the serum. A wide spectrum of malignant and nonmalignant disorders is included in the differential diagnosis of multiple myeloma. A common laboratory finding in most of these diseases is the presence of a monoclonal spike on serum or urinary protein electrophoresis, and it is for this reason that these disorders are often classified as monoclonal gammopathies (Table 1).

Malignant neoplasms of lymphocytes and plasma cells associated with a monoclonal protein spike in the serum or urine are referred to as primary malignan gammopathies. Multiple myeloma and Waldenstrom' macroglobulinemia make up greater than 95% of thi group (Table 1). Although chronic lymphocytic leu kemia and malignant lymphomas are common dis orders, only a small percentage of patients demon strate an "M" spike in serum or urine. Solitar plasmacytomas (intraosseous or extramedullary) with out evidence of dissemination do occur. In most in stances, with or without treatment, progression to mul tiple myeloma usually results. The interval between th diagnosis of a plasmacytoma and the development o multiple myeloma, however, may be many years.[10]

The clinical and laboratory findings in patients with Waldenstrom's macroglobulinemia more closely re semble those seen in patients with chronic lymphocyti leukemia or lymphomas than multiple myeloma. They usually have hepatosplenomegaly and rarely have lyti bone lesions. The neoplastic cell has morphologic fea tures common to both lymphocytes and plasma cell (plasmacytoid lymphocytes). Bone marrow biopsy re veals a diffuse pattern of infiltration that is in distinguishable from the pattern of involvement seen in chronic lymphocytic leukemia. The diagnosis is estab lished by the finding of a monoclonal 19S IgM spike or serum protein electrophoresis.

The heavy chain diseases are so designated because of the finding of a monoclonal protein in the serum and urine which has H chain antigenic determinants but not L chain determinants and which structurally resembles the Fc fragment. The clinical manifestations of these diseases vary greatly and depend on the class of monoclonal H chain produced.[17]

Amyloidosis is included among the primary malignant gammopathies because of the recent finding that the major component of the amyloid material in primary amyloidosis and in amyloidosis associated with multiple myeloma structurally resembles the V_L region of κ or λ L chains.[18] In secondary and familial forms of amyloidosis, the amyloid material is composed of a polypeptide which has approximately the same molecular weight as L chains, although they are not antigenically identical.[18] Plasmacytosis in the bone marrow is a frequent finding in both primary and secondary types.

A monoclonal serum protein spike occurs in association with other malignant diseases (i.e., carcinoma of the large bowel and biliary tract) and with many nonmalignant disorders (i.e., connective tissue diseases) (Table 1). An "M" spike in the serum or urine may

Figures 1, 2 and 3 appear in *Fundamentals of Clinical Hematology*, 4th Edition, 1976, and are reprinted by permission of the authors, B. S. Leavell and O. A. Thorup, Jr., and the publishers, W. B. Saunders Co., Philadelphia.

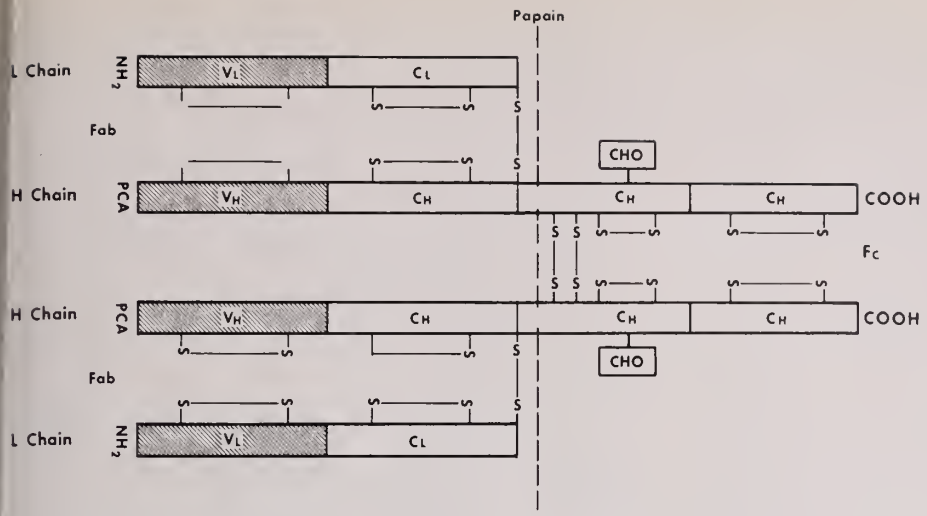


Fig. 1. Schematic structure of 7S IgGl from data by Edelman et al.[16] NH_2, amino-terminal end; PCA, pyrrolidine-carboxylic acid; V_L, variable region of the light chain; V_H, variable region of the heavy chain; C_H, constant region of the heavy chain; CHO, carbohydrate; Fab, antigen-binding fragment; FC crystallizable fragment.

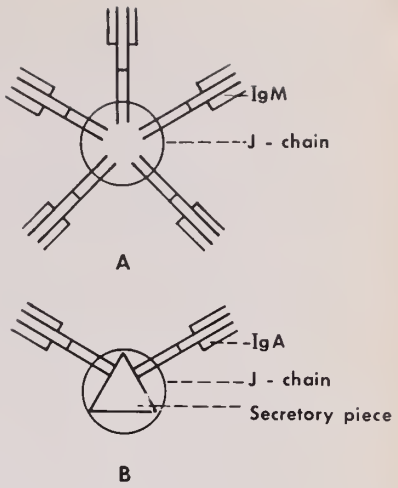


Fig. 2. Schematic structure of IgM Pentamer (A) and Secretory IgA (B).

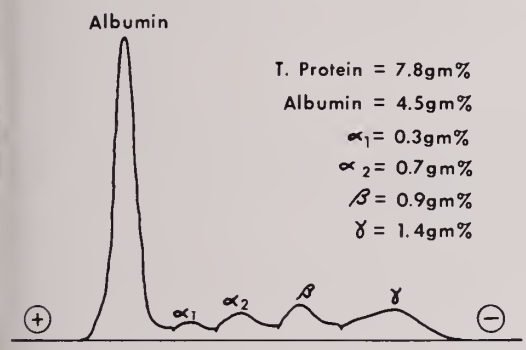
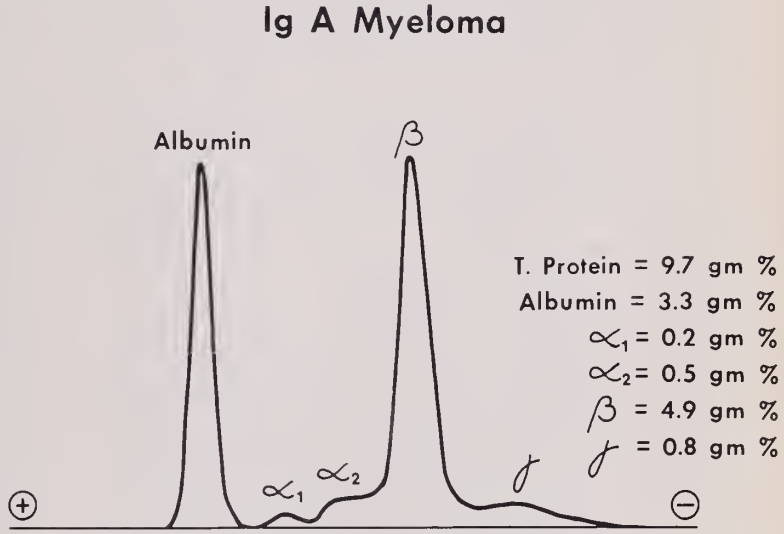


Fig. 3 (above). Normal serum protein electrophoretic pattern.

Fig. 4 (right). Serum protein electrophoretic pattern from a patient with IgA miltiple myeloma.



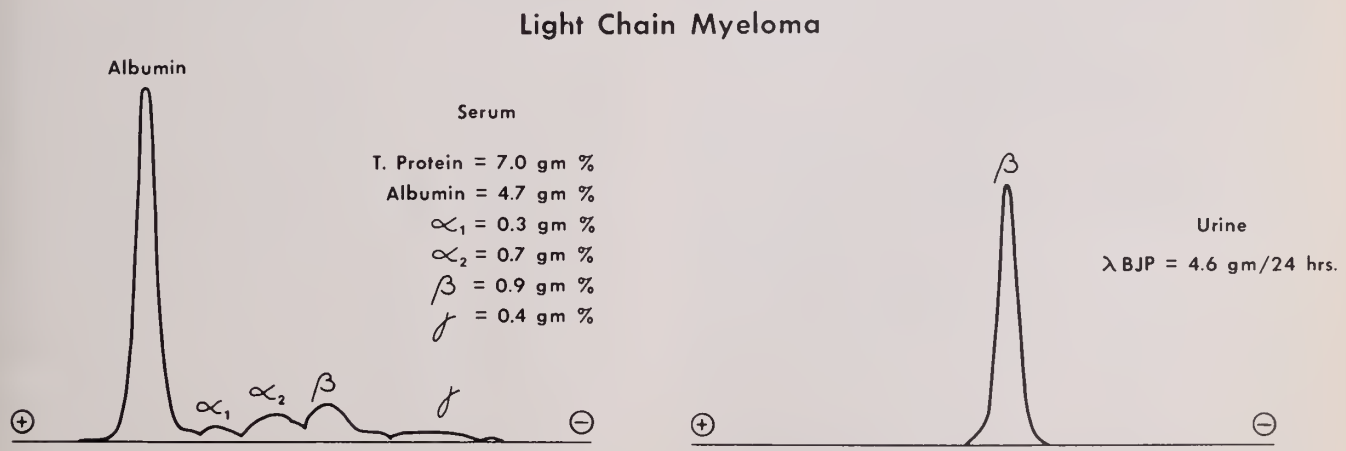


Fig. 5. Serum and urinary protein electrophoretic pattern from a patient with light chain (Bence Jones) multiple myeloma.

Table 1

DISORDERS OF LYMPHOCYTES AND PLASMA CELLS

ASSOCIATED WITH MONOCLONAL GAMMOPATHY

Primary Malignant Monoclonal Gammopathies

1. Multiple Myeloma (84%)*
2. Plasmacytoma (1-2%)
3. Waldenstrom's Macroglobulinemia (12%)
4. Heavy Chain Disease (<1%)
5. Amyloidosis (<1%)
6. Chronic Lymphocytic Leukemia (∿1%)
7. Malignant Lymphomas (∿1%)

Secondary Monoclonal Gammopathies

1. Associated with Other Neoplasms
   A. Carcinomas, i.e., bowel and biliary tract
2. Associated with Non-neoplastic Disorders
   A. Cold agglutinin disease
   B. Lichen myxedematosus
   C. Pyoderma gangrenosum
   D. Goucher's disease
   E. Connective tissue disorders
   F. Autoimmune diseases
   G. Others:
      Chronic infections, durg reactions, etc.

Idiopathic Monoclonal Gammopathies

1. Benign Monoclonal Gammopathy
2. Early Primary Malignant Monoclonal Gammopathy
3. Secondary Monoclonal Gammopathy

*Percentages represent the relative frequency

occur in the absence of any underlying disease process and should be referred to as "idiopathic monoclonal gammopathy." In most of these patients, multiple myeloma or some other disorder known to be associated with monoclonal gammopathy will develop.[19] If no other disorder develops after many years, only then is the term "benign monoclonal gammopathy" appropriate. The demonstration of lytic bone lesions is often the single most important diagnostic factor in borderline cases. A particularly difficult diagnostic and therapeutic problem is the patient who presents with generalized osteoporosis, a serum "M" spike and an increased percentage of plasma cells in the bone marrow (usually less than 20% mature plasma cells). Some of these patients may live for many years without developing overt multiple myeloma and are referred to as patients with "pseudomyeloma."[20]

Once the diagnosis of multiple myeloma is made, treatment should usually begin immediately. Therapy consists of an alkylating agent (i.e., melphalan, cyclophosphamide) alone or in combination with corticosteroids on an intermittent or continuous schedule. I prefer the combination of melphalan and prednisone on an intermittent schedule. Maintenance usually consists of the same combination of drugs at lower doses as tolerated. Approximately 70% of patients will show an objective response to this regimen (i.e., a decrease of 50% or more in the concentration of the "M" spike in the serum or urine). The median survival of responders is three- to seven-fold greater than the median survival of patients who receive no chemotherapy or fail to respond to chemotherapy.

Radiotherapy is very important in the management of patients with multiple myeloma. Most patients will require local radiotherapy for painful bone lesions or pathologic fractures during the course of the disease. The amount of radiation should be kept to a minimum to avoid bone marrow suppression which interferes with effective chemotherapy.

General therapeutic measures (i.e., use of analgesics, maintaining adequate hydration, employment of back braces for vertebral involvement, prompt treatment of infections) are also very important in the overall management of patients with multiple myeloma.

Dr. Hook: Thank you very much, Dr. Hess. It occurred to me with your last remarks that if this disease has been developing for many years before becoming clinically manifest and patients who fail to respond to chemotherapy commonly die within one year, we must be initially encountering these patients in the terminal phase of their disease. It is unfortunate that we have been unable to develop techniques that might lead to earlier diagnosis. Since several disease entities are associated with monoclonal gammopathy and increased numbers of plasma cells in the bone marrow, would you review once again how one makes a definitive diagnosis?

Dr. Hess: The roentgenographic demonstration of lytic bone lesions and the morphologic demonstration of immature plasma cells in the bone marrow ("mye-

)ma cells") are the most important diagnostic find-)gs. If osteolytic lesions are absent, even in a patient /ith 20-30% mature plasma cells in the bone marrow nd a monoclonal spike in the serum, one is often esitant about making the diagnosis and starting ther-py, especially if the patient is asymptomatic. A high erum level of the monoclonal immunoglobulin greater than 2.0 grams per 100 ml) in association with decreased level of polyclonal ("normal") immuno-globulins also is in favor of the diagnosis of multiple nyeloma.

Dr. Byrd S. Leavell: Dr. Hess has given us an excellent review of this problem from many angles. It is difficult for me to understand why myeloma is nearly always a widespread disease at the time of diagnosis. Although one does see solitary plasmacytomas, it must be extremely rare to diagnose myeloma on a bone marrow in an asymptomatic patient. We do hundreds of bone marrow examinations each year, and I cannot recall finding multiple myeloma "accidentally." Thus, if this malignant clone of cells has been present for many years, as Dr. Hess mentioned, it is hard for me to understand why they are not discovered in the "prodromal" period.

Dr. Merle Sande: Just a comment about the infections that Dr. Hess mentioned. We've come to think of multiple myeloma as a neoplasm characterized by defects in humoral immunity. Indeed, if you look at the causes of infection in patients with multiple myeloma, they tend to have infections caused by Streptococcus pneumoniae or Hemophilus influenzae because of decreased production of opsonizing antibody. However, when these patients receive chemotherapy and become neutropenic, they fall into the category of patients with leukemia, lymphoma and other tumors, who are neutropenic and have infections caused by gram-negative organisms.

Dr. Hess: This is true. In a report of infections occurring in hospitalized patients with multiple myeloma, most of whom were receiving chemotherapy, gram-negative bacteria were the most common organisms isolated.[21]

Dr. Kline Bolton: I wanted to comment on the renal failure that occurs with multiple myeloma. I think that dehydration is probably the most important factor. I think there is little doubt that people do get renal failure after intravenous pyelography for precisely this reason. There have been many attempts to show that the contrast material is involved in the pathogenesis of the acute renal failure, but if one mixes the dye in vitro with various quantities of urine and light chains, precipitation cannot be induced without very extreme changes in pH. Therefore, intravascular volume depletion seems a more likely cause of acute renal failure. Hydration should be maintained intravenously during and for a short time after the procedure.

Dr. Thomas Hunter: My question has to do with the reversibility of the renal lesion after chemotherapy for multiple myeloma. Does one see this?

Dr. Hess: Review of pretreatment and post-treatment renal biopsies supplies little evidence that would indicate a significant degree of reversibility in "myeloma kidney." There are many patients who present with azotemia and Bence Jones proteinuria whose renal failure improves with therapy (i.e., hydration, treatment of infection and chemotherapy); the cause of the azotemia in these patients is not known in most instances.

Dr. Hook: And a final comment from Dr. Thorup.

Dr. Oscar Thorup: I would like to call attention to an article by Durie and Salmon.[22] They have developed a technique whereby one can quantitate the amount of immunoglobulin being produced by each myeloma cell and from this data determine the total tumor burden at any particular time in the course of the disease. From studies of this type, it appears that the growth rate of these malignant plasma cells follows a biphasic pattern, with a very rapid growth rate for the first few years followed by a much slower growth rate by the time the disease becomes clinically apparent. Consequently, calculations of the duration of the disease from cell kinetic studies done at the time of diagnosis probably overestimate the time the disease has been present.

Dr. Hook: Our time is up. Thank you very much.

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When buying Oriental rugs, you can make a better selection if you know something about them.

1. Your home is not a museum; it is a place for your comfort, pleasure and relaxation. When selecting an oriental rug, first evaluate how much you like a particular rug and then consider how it complements your decor.
2. All sizes and colors of Oriental rugs are available, suitable for every room in your home including the bathroom, hallways and steps, and a child's room. The money you are willing to invest in a rug should be relative to the degree of its use and enjoyment. Furnish with rugs first the rooms which are used most often.
3. When you have found several rugs you like, compare their prices. If two similar rugs vary considerably in cost, be sure you do not pay the higher price for very minor differences.
4. Color and design (the balance of different parts of patterns and the proper coordination between border and field) are important considerations in selecting a rug.
5. Do not hesitate in selecting a rug which to some may appear "too loud" or "too strong" since soft colors and simple designs often lose their novelty sooner in the home.
6. Oriental rugs are named after the village or, more often, the region of their origin. The quality of a rug may vary greatly regardless of the name. You should judge a rug by its individual merits (workmanship, wools, use of color and design) and not by its name or signature alone.
7. Some irregularity of shape, color, design and workmanship is acceptable in a handmade oriental rug. However, the discrepancies should not be extreme.
8. Natural silk rugs are expensive and are good investments. Be selective in your choice since some synthetic silk rugs are also available.
9. In antique rugs (50 years and older) age and condition are significant factors in judging the value of a rug. This does not necessarily mean that all older rugs have higher value. If a rug is old, it must be in very good condition, otherwise do not consider purchasing it.

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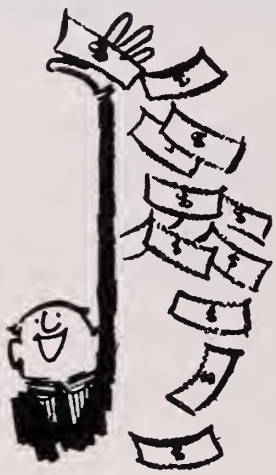
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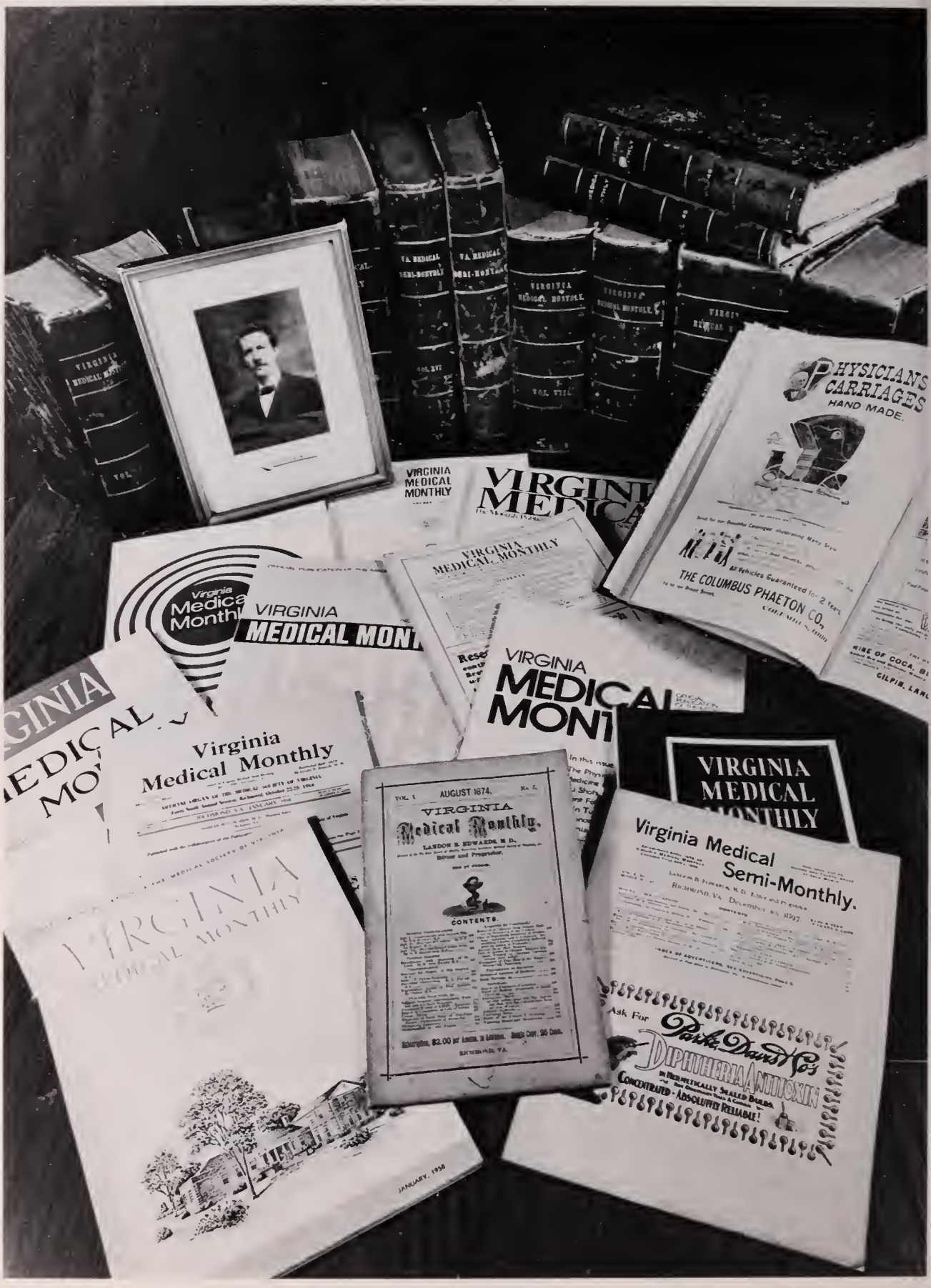
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VIRGINIA MEDICAL EDITORIAL

For a Grand Old Journal, A Fresh Face

WITH this August, 1976, issue the *Virginia Medical Monthly* appears in a new cover and format, occasioned by a change of printers. For a few issues things will be highly experimental. Your editors intend that all will soon be polished and running smoothly for you.

This grand old journal is 102 years old this year. The covers shown in the photograph on the page at left illustrate its long and vigorous life. The small-sized issue is from the first year of publication, 1874. You will notice that the table of contents appears on its cover. That tradition is this month restored. The caduseus you see on that early cover has been resurrected, too. It is incorporated into the new masthead, page 547.

Shown also is the first issue published under the banner of The Medical Society of Virginia in January, 1918. And, as can be seen, the journal was a semimonthly for a time, from 1896 until the Society became its owner.

The portrait is of Dr. Landon B. Edwards, internist, who founded this journal and was its "Editor and Proprietor" until his death in 1910. He also was a founding member of The Medical Society of Virginia and for many years served as its secretary. And he taught at the Medical College of Virginia. And conducted a large private practice. No wonder he drew his family into the publishing of the journal: the grandson who loaned us this picture, Landon B. Edwards, Jr., Richmond, remembers being pressed into service as proofreader when he was a college student.

The issues here photographed and all the many others are preserved in bound volumes, 24 linear feet of them, in the journal office. It is a great satisfaction to work in the presence of these volumes, and it is a delight to peruse the early issues, with their quaint typography and curious nostrums. In yet another bound volume this issue, too, will reside, continuing the record of the strong and able contribution to medicine of Virginia's physicians.

Lab Tests A La Mode

LIKE fashions in clothing, laboratory tests have their vogues. Occasionally, good reasons for the trends are obvious, as when a better test supplants an older one: the demise of the cephalin flocculation test in the face of the quantitative plasma protein electrophoresis is such a case. At other times, less meritorious reasons for change are obvious: it is more trouble to perform a careful microscopic analysis of a urinary sediment than to check off a request for a 24-hour creatinine clearance on a laboratory slip. And part of the time, the popularity of individual lab tests, like ladies' hemlines or men's hair lengths, seems to go up or down without any apparent reasons at all.

Nowhere in medicine is the trendiness in testing more prevalent than in the fledgling subspecialties of rheumatology and clinical immunology. For a long time, these areas have been underprivileged with respect to available tests. They had nothing to compare with a serum sodium or a plasma cortisol. More recently, with advances in knowledge about the functioning of the immune systems, the number of available analyses has increased rapidly. The accelerating rate of appearance is

due partly to enthusiastic promotion by the discoverers of the tests and partly to aggressive salesmanship by laboratory supply companies. Several of the new tests are of proven usefulness; others are of more equivocal value. In cellular immunology, the enumeration of relative numbers of T and B lymphocytes is a current sport, though its value other than in the diagnosis of immunodeficiency states or in the classification of non-Hodgkin's lymphomas remains to be demonstrated. Humorally-oriented immunologists delight in measuring antibodies to all sorts of arcane nucleic acid antigens, though only the fluorescent antinuclear antibody assay and the measurement of serum DNA binding are clearly of clinical usefulness. Considering the volume of blood and the cost involved in some of these tests, their overuse may leave both the patient and his pocketbook somewhat anemic.

Unlike the cut of one's clothes, however, laboratory tests may be subjected to intensive scientific scrutiny and their validity in clinical situations determined. This is hard work, but it needs to be done. An example of such hard work, involving the performance of 1180 determinations of five tests in sera from 236 individuals is published by Waller on page 561 of this issue of *Virginia Medical*. Results will be reassuring to those who may have worried about not keeping up with the latest technology. The venerable erythrocyte sedimentation rate continues to be a good rough (and inexpensive) index of "inflammation", notwithstanding the occurrence of occasional abnormal results in apparently normal individuals and normal results in sick patients. The test for rheumatoid factor selects with fair reliability those with rheumatoid arthritis, even though a positive is not *required* for the diagnosis since about 30% of patients with rheumatoid arthritis will have negative tests, and even though it is not by itself *diagnostic* of the disease, since positive tests occur in patients with other diseases and even in normal individuals with advancing age. Use of the NBT dye reduction test probably should be restricted to the diagnosis of the very rare chronic granulomatous disease of childhood, for which it is the test of choice. Titers of agglutinins to enzyme-treated immunoglobulines, though of considerable theoretic importance, are not very informative diagnostically. And C reactive protein? The survival value in disease of synthesizing large quantities of a beta-globulin reactive with a particular polysaccharide remains one of the riddles of modern immunology.

SHAUN RUDDY, MD
Richmond, Virginia

The Allergist-Clinical Immunologist Defined

THE allergist of yesteryear no longer exists; a new breed, he has been retrained totally in the past few years to become a clinical immunologist.

The four national organizations of allergy-immunology have responded heroically in updating both national conventions and monthly journals in the past five to eight years. The youngest national organization, the American Association of Clinical Allergy and Immunology, has used immunology in its name. The newly developed American Board of Allergy and Immunology is the final product of the efforts of these four national organizations plus an equal contribution by the subspecialty boards of pediatrics and internal medicine.

We have crossed the boundaries of many specialties in today's medicine. Has not this been a truism since the first division of specialties and subspecialties in medicine? We are becoming a necessary repository of knowledge in clinical immunology; the allergist-immunologists are trying desparately to fill a gap in medical knowledge and to become a "library" and clearing house for the massive amount of material they deal with.

The primary point I would like to make is that today's allergist-immunologist has tools at his command for the first time to determine with precision exact figures and exact facts. We have at long last become a specialty that can measure the patient and our treatment results accurately. This has been the hope and dream of many of the older allergists in this country. With the new clinical allergist-immunologist, the dream is now a reality.

L. PERRY HYDE, MD
Pulaski, Virginia

LETTERS TO THE VIRGINIA MEDICAL EDITOR

A Vote Against Compulsory Membership

In my opinion it will be a serious mistake if the House of Delegates votes for compulsory AMA membership as a requirement for Medical Society of Virginia membership.

There are many of us who disagree with AMA's awe of the federal government, with its frequent hesitancy to oppose actions obviously detrimental to medicine or steps toward government takeover of medical care. Many of us have expressed our displeasure by resigning from the AMA in protest. If this action is taken, our Medical Society will find out, too late, just how numerous we are.

The AMA has let us down too often. Recently, after a threatened suit of the government brought success in its grasp, the AMA "negotiated" conditions which donated to the government all it wanted in the first place. AMA's objections to Medicare were post facto, as have been all its actions since. Nationalized medicine would not be presumed inevitable if the AMA truly united against it and opposed each step of government control of medicine. Pious denials do not erase actions or lack of action over the years.

May our Delegates give serious thought to this question before the meeting. Prevent compulsory AMA membership! It will not be in the best interests of The Medical Society of Virginia.

R. G. McAllister, MD
Richmond, Virginia

A Question of Education and Competence

Many Virginia physicians received recently a letter and brochure from the Virginia Optometric Association announcing their purported new role as updated diagnostic primary health care providers.

Whatever role optometrists may play in future "health care delivery systems," patients must be protected from and warned about placing their confidence and trust in the care of practitioners whose claims of expertise may not be justified.

The practice of optometry is separate from the practice of medicine, osteopathy and dentistry. It is isolated from hospital rules and regulations and from scrutiny by physicians. Evaluations as to competence and licensure are administered only by other optometrists.

As long as optometric services are limited basically to refracting and fitting lenses, as Virginia laws presently state, there are few questions concerning public safeguards. However, as optometrists attempt to expand definitions of optometry to include the diagnosis and treatment of disease, including use of drugs, as in West Virginia and other States, serious questions as to competence to perform such tasks are raised.

Optometric education, despite the length of time spent in school, does not compare to the education and training of a physician. Their level of competence to comprehend problems and experiments based upon sound scientific principles sufficient to produce value judgments comparable with those of medicine, osteopathy or dentistry has not been adequately demonstrated. Optometrist accreditation methods have opposed opinions of recognized experts of eye diseases, ophthalmologists and ophthalmic pathologists.

As long as these basic differences in education and competence exist, optometry can never mesh properly with the practice of medicine nor become a true part of the "medical team." Optometric services may help people to see clearly through lenses, but such services clearly are not to be confused with the practice of medicine.

John F. Nowell, MD
Annadale, Virginia

MEETINGS ABOUT MEDICINE

Members of The Medical Society of Virginia are invited to submit entries for this calendar. The information should be received five weeks before publication by the Managing Editor, 4205 Dover Road, Richmond VA 23221.

September

Symposium on **Diagnostic Ultrasound** in **Gastroenterology** and **Urology,** sponsored by the Department of Radiology, Gastroenterology and Urology of The Johns Hopkins Medical Institutions, The Johns Hopkins Hospital, *Baltimore,* September 9-10. Janet B. Hardy, MD, Department of Continuing Education, The Johns Hopkins University School of Medicine, 720 Rutland Avenue, Room 17, Baltimore 21205.

21st Annual Angus M. McBryde **Perinatal** Symposium, sponsored by Division of Perinatal Medicine, Duke University Medical Center, *Durham, North Carolina,* September 15-16. Angus M. McBryde Perinatal Symposium, Box 3967, Duke University Medical Center, Durham 27710.

2nd Annual Postgraduate Course in **Adolescent** Medicine, sponsored by the Section of Adolescent Medicine, Medical College of Virginia, Richmond Hyatt House, *Richmond,* September 16–18. George M. Bright, MD, Box 151, MCV Station, Richmond VA 23298.

Diabetes 1976, sponsored by Division of **Endocrinology** and **Metabolism** and Department of Continuing Education, MCV, Medical College of Virginia, *Richmond,* September 23. Department of Continuing Education, School of Medicine, MCV, Box 91, Richmond 23298.

October

Topics in **Gastroenterology** and **Liver Disease:** Medical and Surgical Aspects, sponsored by the Departments of Medicine and Surgery of The Johns Hopkins School of Medicine, Johns Hopkins Medical Institutes, *Baltimore,* October 7-9. Willis C. Maddrey, MD, Blalock 932, The Johns Hopkins Hospital, Baltimore 21205.

Diabetes Day, sponsored by National Institutes of Health, Masur Auditorium, NIH Clinical Center *Bethesda, Maryland,* October 16. Jesse Roth, MD Diabetes Branch, NIH Clinical Center, Room 8S 243, Bethesda 20014.

November

1976 Annual Meeting—The Medical Society of Virginia and Auxiliary, Williamsburg Conference Center *Williamsburg,* November 4-7. Presiding Officer Raymond S. Brown, MD, Host Society: Portsmouth Medical Society, Arthur A. Kirk, MD, Chairman of Arrangements.

Breaking Affective Barriers for the **Handicapped,** sponsored by Virginia Council on Health and Medical Care, Inc., Hotel Roanoke, *Roanoke, Virginia,* November 22-23. Edgar J. Fisher, Jr., Director, Virginia Council on Health and Medical Care, Inc., PO Box 12363, Central Station, Richmond 23241.

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VIRGINIA MEDICAL OBITUARY

James Grayson Campbell, MD

Dr. James Grayson Campbell, anesthesiologist, died of leukemia on June 1 in a Richmond hospital. He was 46 years of age.

After his graduation from the College of William and Mary with degrees in education, Dr. Campbell was a school administrator and teacher in Norfolk and Portsmouth. He then took postgraduate work at the University of Virginia and the University of Richmond and received his medical degree from the Medical College of Virginia in 1965. He served with the army in Korea in the early 50's.

Dr. Campbell is survived by his wife, a son and a daughter.

Carolyn Dale Candler, MD

At 35 years of age, Dr. Carolyn Dale Candler died June 5 at her home in Richmond. Dr. Candler, an anesthesiologist, was a native of Lynchburg. She was graduated from Mary Washington College, Fredericksburg, and the Medical College of Virginia, Richmond. She took her residency and internship at MCV and was on the MCV staff until 1973, when she joined the staff of Chippenham Hospital, Richmond.

She is survived by her father and two sisters.

Charles Yeatman Griffith, MD

On February 11, 1976, the Northern Neck Medical Association lost one of its most eminent and beloved members and Westmoreland County one of its most distinguished sons in the death of Dr. Charles Y. Griffith. He was 72 years of age and had been a member of this association since the first days of his practice in the Northern Neck area.

He was born at Hague, Virginia, on August 23, 1904, a son of Phillip Smith and Emily Yeatman Griffith. His early education was in the local schools, from which he entered William and Mary College. His MD degree was earned at the Medical College of Virginia, and he returned to his native county in 1930 to practice medicine.

Success crowned his efforts from the earliest day. Possessed of superior skill in his profession, untiring energy, love of his fellow man, he had in addition a charming personality. To have known him well was an honor and a privilege, both to his patients and his fellow physicians.

He lived at "Boscobel" near Mt. Holly, where he shared an office with his son, Dr. Lloyd Tayloe Griffith. Though suffering some cardiac problems in his late years, he continued in active practice and had seen his patients as usual the day of his death. In the words of the editor of the local paper, he was indeed "a legend in his own time, practicing medicine and living life with grace, charm and wit to the absolute fullest, near where he was born and reared, in his beloved Westmoreland, which he, with rightful pride, often referred to as 'the Athens of America'."

Aside from his profession he was an active churchman, being a member of Yeocomico and Nomini Episcopal churches. He formerly had served Cople Parish as senior warden and vestryman.

He had wide business and farming interests and was a director of the Bank of Westmoreland. In addition to being a member of the Northern Neck Medical Association, he was also a member of the American Medical Association, The Medical Society of Virginia, the Society of the Cincinnati, and the Commonwealth Club.

He is survived by his wife, Mrs. Louisa Tayloe Griffith, and his son. There are three grandchildrend, Mary Carroll, Lindsay Carr and Charles Tayloe Griffith.

Services were held at old Yeocomico Episcopal Church at Tucker Hill, which could hold but a small part of the great crowd. He has gone away for awhile; however, the fond memories he has left us will not soon pass away.

J. Motley Booker, MD,
The Northern Neck Medical Association

Hugh Wilfred Clement, MD

Dr. Hugh Wilfred Clement, Kingsport, Tennessee, died in a Kingsport hospital on March 10, 1976, at the age of 76 years. He was a general practitioner and had been a member of The Medical Society of Virginia for 32 years.

A native Canadian, Dr. Clement was graduated from McGill Medical School and trained at St. John Hospital, New Brunswick. He began his practice in Virginia at Toms Creek, moving later to Coeburn. Since his retirement he had lived in Kingsport with a daughter, who survives him.



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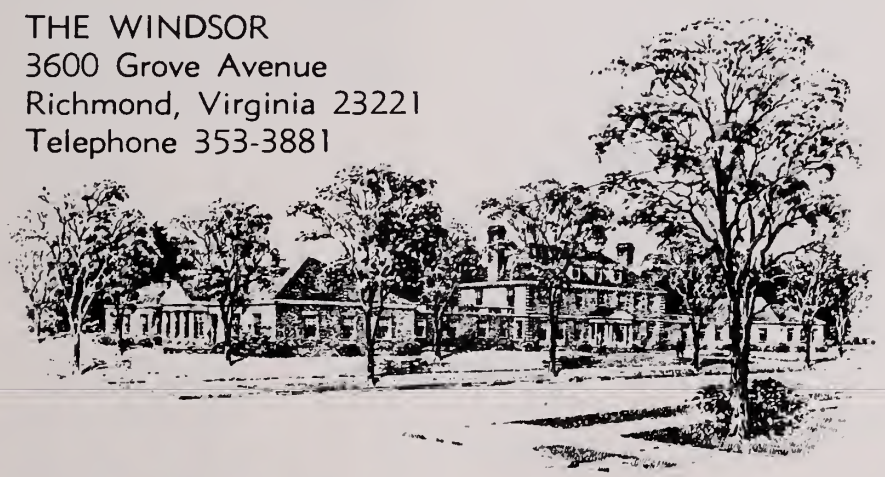
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THE 1976 ANNUAL MEETING
NOVEMBER 4-7

Virginia Hospitals Bank Cancer Information

The Virginia Tumor Registry is now ready for statewide operation. This central, computerized bank of information about cancer cases and their followup results has been operating in a small, experimental way for six years, but it is now proven and perfected, according to Dr. Eugene R. Perez, Richmond. The Registry was established by the Virginia Regional Medical Program, of which Dr. Perez is executive director.

Twelve hospitals over Virginia are contributing to the Registry, providing uniform data on cancer patient care. This data is available to aid in the treatment of cancer patients, in research, and in the education of health personnel. Dr. Perez, a surgeon, is the Registry's director. Dr. William J. Munsie, Fredericksburg pathologist, is the associate director.

The Registry records such information as site and type of cancer, the stage of the disease at diagnosis or first treatment, and the type of treatment given. It also provides for annual followup reports throughout each patient's life. Thus can come, in time, a definitive picture of cancer over Virginia, including incidence patterns by sex and age, survival analyses, the most common sites, and other key elements.

The first comprehensive report on the Registry, a handsome softcover book of blue and buff, includes graphically presented data on nearly 14,000 Virginia cancer cases, these involving 56 sites in the body, with three-year survival data for each of these sites. It was edited by Dr. Munsie and published by the Virginia Regional Medical Program.

For hospitals interested in establishing their own registries, the Program offers a handbook on cancer registry operations.

AMA Joins NC In Court

The American Medical Association and the North Carolina Medical Society have petitioned to join the State of North Carolina as coplaintiffs in legal action against the federal government to prevent further implementation of the new federal health planning law. The original suit, filed in April, charged that the new law would force the state to violate its own constitution or lose eligibility for federal health funds.

In their complaint filed in May, the medical associations contest the constitutionality of the new federal health planning law, passed in 1974 and now being implemented, contending that it violates at least five amendments to the US Constitution.

Virginia TV Viewers See Award-Winning MEDIX Show

MEDIX, the popular television series sponsored by the North Carolina pharmaceutical firm of Burroughs Wellcome, is currently being shown on three TV stations serving Virginia viewers. In Norfolk, WAVY carries the show at 3:30 o'clock Sunday afternoons; WLVA, serving a Roanoke/Lynchburg audience, offers it at 3 o'clock each Saturday. In Maryland, WBAL/Baltimore presents the show on Tuesday mornings.

Additional Virginia stations are being urged to offer the series, which was originated by the Los Angeles County Medical Association. It consists of weekly 30-minute segments on medicine and health, such as "Lupus: Wolf in Disguise", "Breathing Made Hard", "Strike Back at Strokes", "Sexual Communication".

MEDIX has twice received the television industry's top award, the Emmy, as well as the Howard Blakesley Award of the American Heart Association and recognition from the American Medical Association. In many areas, county and state medical societies are cosponsoring the show. The show's emphasis is on providing useful information to the lay public. This serious intent is developed in lively fashion and the show has gathered an enthusiastic national audience.

2nd District Physicians Sponsor a Candidate

Charles E. Davis, Jr., MD, Norfolk, is being sponsored as a candidate for the office of president-elect of The Medical Society of Virginia by physicians of the Norfolk Academy of Medicine, according to a letter to *Virginia Medical* from Dr. Robert A. Morton, Academy president.

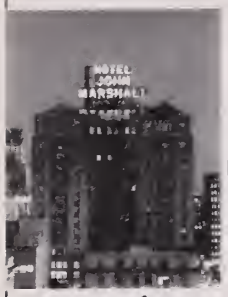
Doctor Davis, a surgeon, is MSV councillor from the 2nd district and president of the Virginia Surgical Society. A native Virginian, he was graduated in 1940 from the University of Virginia School of Medicine, Charlottesville, where he also took his residency and was subsequently instructor in surgical pathology and surgery. He is now Chief of Surgery, Norfolk General Hospital, and Director of the Department of Surgery at DePaul Hospital, Norfolk.

His honors and appointments comprise a lengthy list. Among them are membership in Alpha Omega Alpha, honorary medical society, and the Southeastern Surgical Congress; Fellow, American College of Surgeons; Diplomate, American Board of Surgery. He has contributed significantly to the medical literature and is a member of the Editorial Board of *Virginia Medical*.

Westbrook Psychiatric Occupies New Building

The new 176-bed Westbrook Psychiatric Hospital in Richmond is in operation, a beautiful building with five patient wings radiating from a central area that contains administrative offices, supporting services, and recreational facilities. The new hospital is on the site occupied by Westbrook since its founding in 1911, on the former estate of Maj. Lewis P. Ginter. Some of the original buildings were taken down to make room for the new hospital, but many appointments were retained and incorporated in the new structure.

Dr. John R. Saunders is Westbrook's medical director.



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WHO'S WHO IN VIRGINIA MEDICINE

Dr. Thomas W. Murrell, Jr., *Richmond,* was elevated to the presidency of the American Dermatological Association when it held its 100th anniversary meeting in Williamsburg in May. The presidential post is one in which Dr. Murrell is well versed: he is a past president of The Medical Society of Virginia, the Richmond Academy of Medicine, and the Capital Area Comprehensive Health Planning Council. Dr. Murrell is clinical professor of dermatology at the Medical College of Virginia.

Dr. Donald M. Vickery, *Herndon,* is the coauthor of a medical guidebook for the layman that is finding popular success. It is *Take Care of Yourself: A Consumer's Guide to Medical Care,* published by Addison-Wesley, and it deals with the decision as to whether to go to the doctor when confronted with certain symptoms or signs. The book went into a rush second printing a week after its release in May.

Dr. Vickery, a general internist, serves several days a week in the Medical College of Virginia's Fairfax Family Practice Center, which is a training unit for family doctors under MCV's Department of Family Practice. The impetus for his book came from his private practice and that of his coauthor, Dr. James F. Fries of the Stanford University Medical School. Many persons were coming into their offices who didn't need to be there, they observed.

A review of the book is to appear in these pages in a coming issue.

Dr. Richard H. Fisher, *Salem,* ha been elected president of the Vir ginia Orthopaedic Society by its 15 surgeon-members. No stranger t honors, Dr. Fisher is the immediat past president of the internationa Association of Bone and Joint Sur geons. He is senior orthopedic sur geon of the Lewis-Gale Clinic, Sa lem.

The **Byrd Stuart Leavell** profes sorship of medicine is to be estab lished at the University of Virginia Charlottesville, by Dr. Leavell' friends, students and associates t honor his 45-year association wit the university. The professorshi will be assisted by the state's emi nent scholars program and privat contributions.

Dr. Leavell, now 65, enrolled i the university's medical school i 1931 after graduation from Virgini Military Institute. He has bee chairman of the department of med icine, associate dean of the schoo and chief of the division of hema tology. He is coauthor with Dr. Os car Thorup of the textbook, *Clinica Hematology*. In 1972 he was give the alumni association's distin guished professor award. An histori cal article by Dr. Leavell abou Thomas Jefferson will soon be pub lished in this journal.

Dr. Khalid J. Awan, *Norton,* is th author of an article in a recent issu of the *Southern Medical Journal.* Ti tled "Mikulicz's Disease and Mikul icz's Syndrome," it describes th pathogenesis, clinical manifesta tions, and historical development o the disease and the syndrome, an recommends that the term "Mikul icz's syndrome" be dropped t avoid confusion with the rare an well defined entity, "Mikulicz's dis ease." Dr. Awan's article, "Indirec Traumatic Optic Atrophy," ap peared in the May issue of the *Vir ginia Medical Monthly*, and anothe manuscript of his authorship wil appear in these pages soon.

Chosen president-elect of the Vir ginia Society of Internal Medicine a

recent meeting was **Dr. Philip odilosso,** *Arlington.* **Dr. Wyndham lanton, Jr.,** *Richmond,* is president or 1976.

The Society's 1976 Internist of the ear award was given to **Dr. James I. Moss,** *Alexandria.* **Dr. John H. lollingsworth,** *Roanoke,* was se-cted as the Young Internist of the ear.

Two members of The Medical ociety of Virginia were admitted to ellowship by the American College f Physicians' Board of Regents in a ecent meeting in Philadelphia. They re **Dr. James L. Camp III,** *Char-ttesville,* and **Dr. Jack D. Proctor,** *Richmond.*

Honored recently with a medal nd an award for his work in the lcoholism treatment field was **Dr. bbe C. Hoff,** *Richmond.* Dr. Hoff is nedical director of the Medical Col-ege of Virginia unit of the State Health Department's alcohol stud-es and rehabilitation program. He was cited for his contributions to professional knowledge about alco-holism and its treatment by the American Medical Society on Alco-holism, which is a component of the National Council of Alcoholism.

Dr. J. Shelton Horsley III, *Char-lottesville,* coeditor of the Cancer Trends series in this journal, is slated to join the Medical College of Virginia at Richmond late this sum-mer as professor of clinical oncology and professor of surgery at the Uni-versity of Virginia School of Medi-cine.

A native Richmonder, Dr. Hor-sley continues a distinguished medi-cal heritage. His grandfather, Dr. J. Shelton Horsley, a general surgeon, was president of The Medical Society of Virginia in 1927; he and a son, Dr. J. Shelton Horsley, Jr., a neurosurgeon, practiced together at St. Elizabeth's Hospital, Richmond, until the son's death in 1940. An uncle of Dr. Horsley III, the late Dr. Guy W. Horsley, also served as MSV president, in 1961; the uncle and Dr. Horsley III were in private practice together in Richmond be-fore Dr. Horsley III assumed his post in Charlottesville in 1965.

Leading the Virginia Society of Ophthalmology and Otolaryn-gology in the coming year are **Dr. John F. Nowell,** *Annandale,* presi-dent; **Dr. Neil Callahan,** *Portsmouth,* president-elect; **Dr. J. Thomas Ed-monds,** *Accomac,* secretary-treas-urer. They were elected in June at the society's meeting in Williams-burg.

A case report by three Virginia physicians appears in a recent issue of CHEST, the national journal of circulation, respiration and related systems. The authors are **Drs. Hampton R. Bates, L. James Buis** and **Thomas N. P. Johns,** *Richmond,* and their subject is endobronchial histiocytoma. They summarize the clinical features of eight cases; be-cause distant metastases occurred in one of these cases, they recommend reasonably aggressive surgical treat-ment, despite the consensus that this is a benign tumor.

Dr. Charles E. Horton, *Norfolk,* was installed as president of the American Society for Aesthetic Plastic Surgery at its spring meeting in Atlanta.

In a report last month of the spring meeting in Washington of Society principals and Virginia congress-men, the names of nine MSV coun-cilors who attended were not listed. This signal ommission is very much regretted, and their names are here belatedly presented: **Drs. Harold L. Williams,** *Newport News;* **Charles E. Davis, Jr.,** *Norfolk;* **Charles M. Caravati, Jr.,** *Richmond;* **Henry M. Snell,** *Petersburg;* **Girard V. Thomp-son, Sr.,** *Chatham;* **H. C. Alexander III,** *Roanoke;* **Harry C. Kuykendall,** *Alexandria;* **James Hal Smith,** *Chris-tiansburg;* and **C. Barrie Cook,** *Falls Church.*

Virginia Medical Classified

Virginia Medical Classified is a monthly feature. All insertions accepted at the discretion of the Editor. Rates payable in advance: $10 per insertion for 50 words or less, 10¢ per word in excess of 50. Count POB #'s, phone #'s as 2 words each; abbreviations, ZIP codes as 1 word each. Extra $5 for confidential Box #'s. Classified display available at $20 per 50 words. Copy due by the fifth of the month prior to month of publication. Send to the Managing Editor, 4205 Dover Road, Richmond VA 23221.

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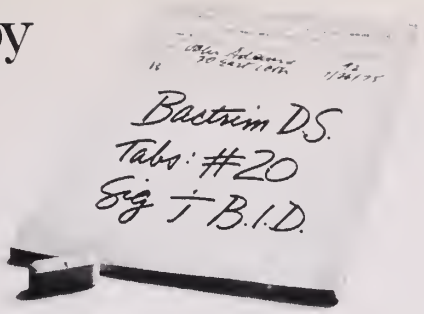
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10-day Bactrim therapy outperforms 10-day ampicillin therapy.



In a multicenter, double-blind study of patients with chronic or frequently recurrent urinary tract infection, Bactrim 10-day therapy outperformed ampicillin 10-day therapy by 27.2%, when comparing patients who maintained clear cultures for eight weeks. Criterion for "clear culture" was 1000 or fewer organisms/ml of urine.

While adverse reactions noted in this study were mild (*e.g.*, vomiting, nausea, rash), more serious reactions can occur with these drugs. See manufacturer's product information for complete listing. Maintain adequate fluid intake; perform frequent CBC's and urinalyses with microscopic examination.

Note: Bactrim tablets were used in these clinical trials. Bioequivalency studies show one Bactrim DS double strength tablet is equivalent to two Bactrim tablets.

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

Bactrim™
(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Chronic urinary tract infections evidenced by persistent bacteriuria (symptomatic or asymptomatic), frequently recurrent infections (relapse or reinfection), or infections associated with urinary tract complications, such as obstruction. Primarily for cystitis, pyelonephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus morganii.*

NOTE: The increasing frequency of resistant organisms limits the usefulness of antibacterials, especially in these urinary tract infections. The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted. **Data are insufficient to recommend use in infants and children under 12.**

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

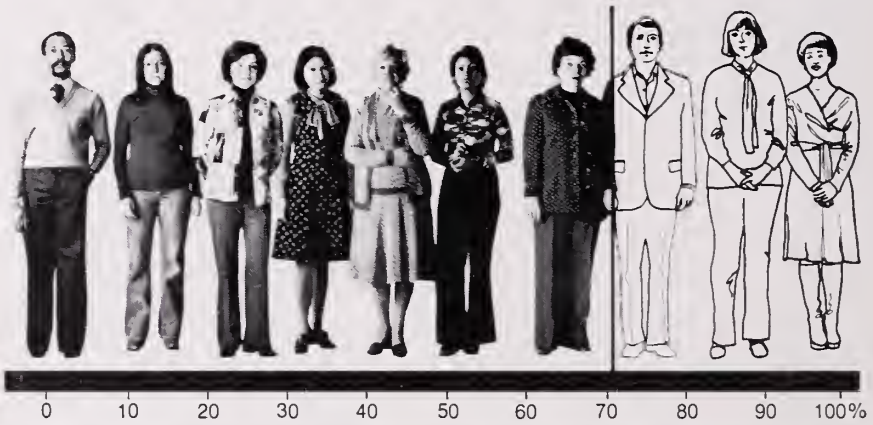
Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

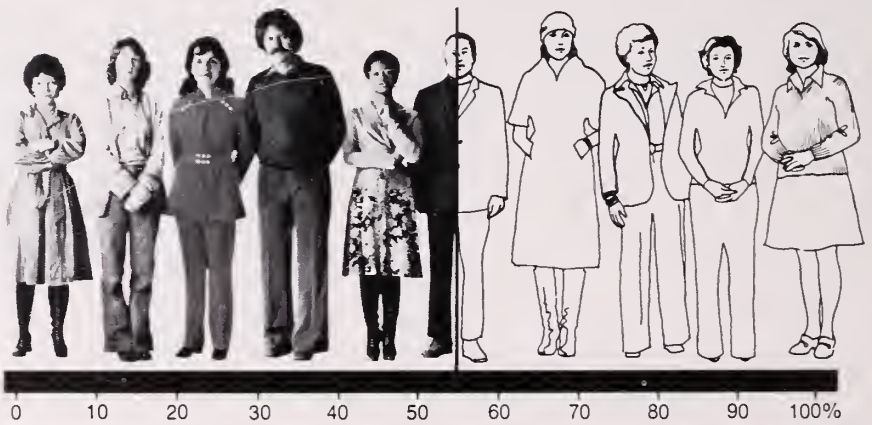
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In a multicenter study of patients with chronic or frequently recurrent urinary tract infections

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†



Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

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Please see summary of product information on preceding page.

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Predominant psychoneurotic anxiety

Associated depressive symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major ymptoms, she is a psychoneu- otic patient with severe nxiety. But according to the escription she gives of her eelings, part of the problem ıay sound like depression. This is because her problem, lthough primarily one of ex- essive anxiety, is often accom- anied by depressive symptom- tology. Valium (diazepam) an provide relief for both—as he excessive anxiety is re- ieved, the depressive symp- oms associated with it are also often relieved.

There are other advan- ages in using Valium for the nanagement of psychoneu- otic anxiety with secondary lepressive symptoms: the psychotherapeutic effect of Valium is pronounced and apid. This means that im- provement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium® (diazepam) IV

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic anxiety states with associated depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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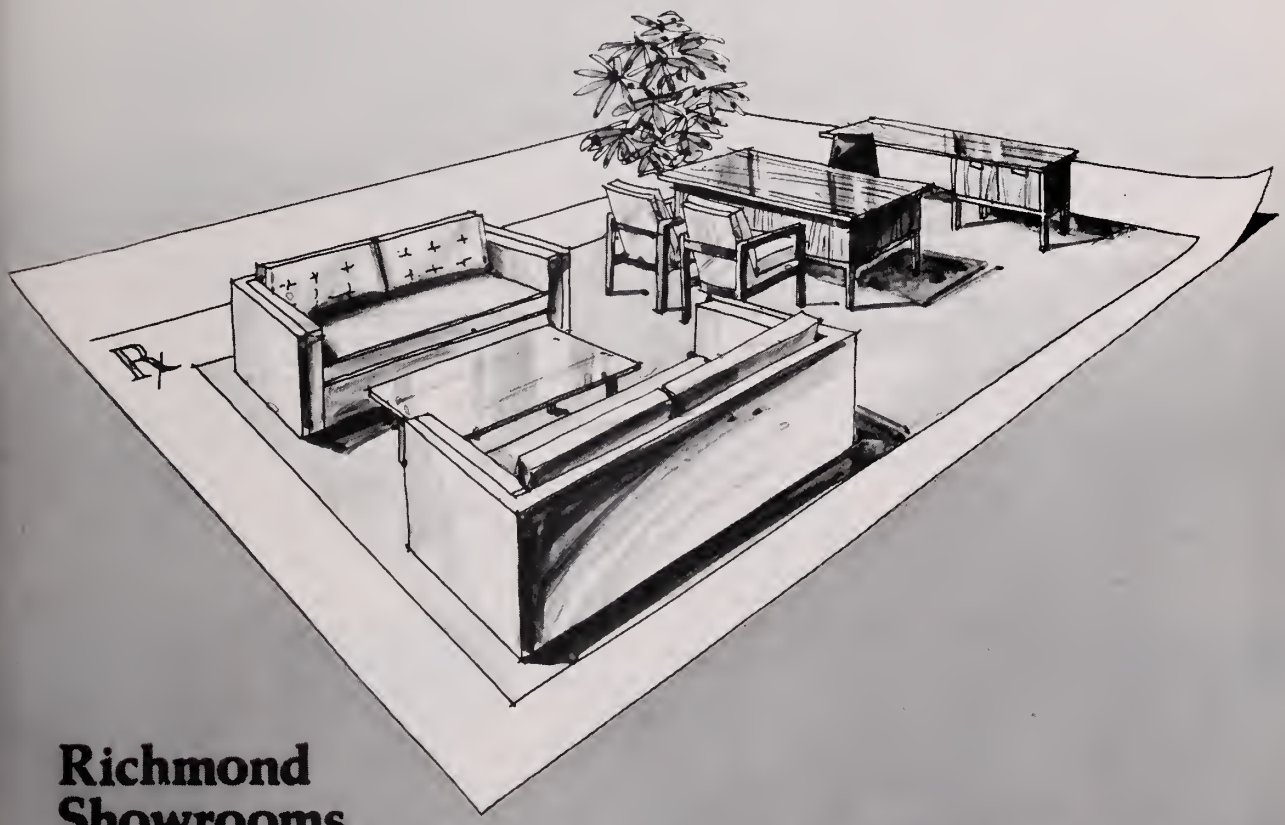
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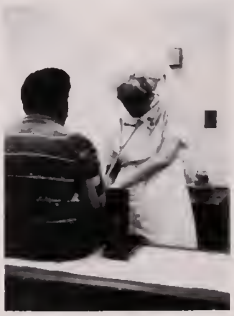
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When buying Oriental rugs, you can make a better selection if you know something about them.

1. Your home is not a museum; it is a place for your comfort, pleasure and relaxation. When selecting an oriental rug, first evaluate how much you like a particular rug and then consider how it complements your decor.
2. All sizes and colors of Oriental rugs are available, suitable for every room in your home including the bathroom, hallways and steps, and a child's room. The money you are willing to invest in a rug should be relative to the degree of its use and enjoyment. Furnish with rugs first the rooms which are used most often.
3. When you have found several rugs you like, compare their prices. If two similar rugs vary considerably in cost, be sure you do not pay the higher price for very minor differences.
4. Color and design (the balance of different parts of patterns and the proper coordination between border and field) are important considerations in selecting a rug.
5. Do not hesitate in selecting a rug which to some may appear "too loud" or "too strong" since soft colors and simple designs often lose their novelty sooner in the home.
6. Oriental rugs are named after the village or, more often, the region of their origin. The quality of a rug may vary greatly regardless of the name. You should judge a rug by its individual merits (workmanship, wools, use of color and design) and not by its name or signature alone.
7. Some irregularity of shape, color, design and workmanship is acceptable in a handmade oriental rug. However, the discrepancies should not be extreme.
8. Natural silk rugs are expensive and are good investments. Be selective in your choice since some synthetic silk rugs are also available.
9. In antique rugs (50 years and older) age and condition are significant factors in judging the value of a rug. This does not necessarily mean that all older rugs have higher value. If a rug is old, it must be in very good condition, otherwise do not consider purchasing it.

I would be happy to help you learn more about Orientals and assist you in any way in your selection.

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VIRGINIA MEDICAL

e 103 September, 1976 Number 9

How Firm a Foundation

Richard E. Palmer, MD, *Alexandria, Virginia*
President, the American Medical Association

"... Hope based on reason and on faith in one's fellow man . . . that s my key message. . . ."

THE HONOR of acceding to your Presidency comes in a very special season—the high summer in America's remembrance of her past. In the dawn's early light of our republic, there is one face I see with particular clarity and sentiment. He was a Virginian and a staunch friend of our profession. An avid collector and reader of books on medicine, he perceived its potential brilliance as a science in an age when it generally had to fumble in the dark. He gave it his help and even his active hand.

If today we physicians feel that we are fall guys for political desperation, let us ever recall that in the deathless eyes of Thomas Jefferson, we are a vanguard of hope. Indeed, hope was the very heart of all his greatest beliefs. If I were to sum up Jefferson's credo in one line, I would say it was hope based on reason and on faith in one's fellow man.

Yes, let me repeat that: Hope based on reason and on faith in one's fellow man. For that is my key message this afternoon. Today, our nation seems to have lost much of the optimism that inspired its birth and its youth. One familiar reason is that the oceans which used to seclude us are now a mere conduit to the world and all its convulsions.

But an even more compelling reason, I think, is the state of the union. The national government has made itself a rigid custodian of the people's common hopes and horizons. It gerrymanders those horizons

Presented as the Inaugural Address at the Annual Meeting of the American Medical Association, Dallas, Texas, June 30, 1976.

". . . how zealously can we accuse the government of lack of faith i us if we lack faith in one another? . . ."

to please or tantalize certain groups or to suit its own opportunism. In industry and transportation, in community planning and home construction, in education and health, the federal government has become the chief arbiter of what is desirable and what is possible. It is far less adept in realizing possibilities, however, than in stimulating desires. Some group has to be blamed and disciplined for the embarrassing gap, and in medical care, that group is the givers of care.

You and I and our fellow physicians find ourselves assailed because the principles, the dynamics and the inescapable costs of medical science cannot easily be accommodated to political whims and will-o'-the-wisps. And instead of settling for a reasonable adjustment to medical realities, government is becoming steadily more dogmatic. Jefferson recognized the evil that such dogmatism could do to our profession. In one of his most notable documents, the *Notes on Virginia*, he observed: "Was the government to prescribe to us our medicine and diet, our bodies would be in such keeping as our souls are now."

For editorial comment, see page 698.

The politicians and bureaucrats, if they are fully conscious of their dogmatism, would contend that it is needed and therefore reasonable. But how much reason was there in the original Utilization Review regulations whereby the misjudgments of lay people could have denied hospital care to the elderly and the Medicaid poor? The courts couldn't see it. How much reason in the Health Planning Act of 1974 with its skyscraper and penthouse of bureaucratic power in contrast with the down-to-earth needs of care? How much reason in the House of Representatives subcommittee report that perverted a tabulation of unconfirmed surgical procedures into a nationwide estimate of unnecessary surgery? How much reason in the Federal Trade Commission complaint against our taboo on unrestricted advertising? Such advertising would pad the demand for our services, pad our costs and undermine our professionalism.

One lesson is clear from all of this meddling: An unreasonable amount of power in the hands of government is inevitably unreasoning power. And there can be no hope unless it is based on reason. Yet, if I were to say that government is the only threat to our hopes as physicians, I would be giving you a half-truth. For how zealously can we accuse the government of lack of faith in us if we lack faith in one another? How fervently can we accuse Washington o trying to "divide and conquer" us if we are so divide that we are conquerable?

We physicians need to move within a single frame work of determination no matter how we may diffe on specific issues or in fields of activity. As President therefore, I will press strongly for unified member ship throughout our federation and unity throughou the ranks of medicine.

To any state and county societies that resist unifie membership, I say: This American Medical Associa tion is your child. You created it primarily becaus you were beseiged by problems that no single stat could handle on its own. You created it especiall because medical education in 1847 was a muddle an a scandal, because any move to improve standards i any state was met by the outcry that students woul be lost to lenient schools in other states. In response belatedly perhaps, but triumphantly, the America Medical Association helped conceive and achieve th Flexner Report.

Over the years, we have expanded our spectrum t legislation, to professional and pharmaceutical stand ards, to the socioeconomics of health, to every are that invokes or endangers our integrity as doctors t man and to society. We can discharge our responsi bilities even more successfully, but only if we have th loyalty of you who fathered us. We can fight all th dragons that beset our profession, but not if you apathy feeds their fires. We are your child. Wh abandon us?

To you who are interns, residents and students o medicine and who may judge us as not idealisti enough or, contrarily, as not militant enough, I hav these words to say: We share your idealism. Examin our National Health Insurance bill built on existin private financing mechanisms and the pluralistic de livery system. Examine our energetic advocacy o better emergency and rural care, better Indian an migrant care, and countless other manifestations o human concern. We have been and will be militant i your behalf. We have a Department of Negotiation to help our component societies bargain for bette medical care, and they in turn can help housestaff d it.

We cannot, however, condone those economic ac tions that would fly in the face of patient care and hence, our common professionalism and idealism Economic action and bargaining without antisocia behavior, without selfish impulsiveness are the civ



Doctor Palmer (left) is sworn in as President by Dr. Raymond T. Holden, Washington, D.C., Chairman of AMA's Board of Trustees. The scene is the Fairmont Hotel, Dallas, preceding Doctor Palmer's delivery of the address published here.

ilized approach. And because that is our approach, it is we of the American Medical Association who are modern, and it is labor unions that tend to be old-fashioned and stale.

To those medical college faculties that feel aloof from the practicing physician and never mention the virtues of the AMA in their classrooms, I have these words to say: You increasingly are seeing that educational grants from Washington entail control from Washington. That control is steadily encroaching on the purposes and parameters of your curriculums and the internal management of your schools. Your very leadership of your students and the direction in which they are being led are at stake. So, like it or not, you have much in common with the practicing physician, in his struggle to preserve his freedom and his professional integrity. Hence, you have much in common with the American Medical Association. Let us go forward together against the dark, for there can be no whistling in it.

To physicians in general, to AMA members and nonmembers alike, I have these words to say: We have a great fortress in this federation. But its purpose is the protection, not the domination, of medicine. It protects the right to puruse medicine according to ancient truths and modern realities. It practices no belligerence, except toward those who would bring harm upon our profession and our services.

". . . People will look to us . . . We will be called upon to sit at the bed-side of the meaning of life itself. . . ."

When harm threatens, we of the AMA fight as hard and as long as we have to. We fight wherever we need to, against an unjust law or regulation or the sinister complexities of the professional liability crisis and the tort system. The day we filed suit against the Utilization Review regulations was our D-Day, for then we made the courts our second front against federal iniquity. And we landed in triumph! We have carried our courtroom campaign forward, against the MAC regulations and against the Health Planning Act, with all of its high battlements and all of its land mines. Congress and the regulatory agencies have long made us wonder what they will do next. With our new legal militance, we are making them wonder what we will do next.

Yet, no matter how vigorously we fight, our gunfire is Jeffersonian reason. Our National Health Insurance bill, for example, and our National Commission on the Cost of Medical Care are reasonable efforts to find the elusive equation between need and meeting the need. Our proposed 19 amendments to the PSRO, to cite a further example, are a reasonable attempt to make it work and keep it from being abused. No matter how reasonably we fight, there are physicians who want us to be above the battle, to devote ourselves exclusively to clinical matters. Only by being in the battle, however, can we preserve the right and the freedom to be above it.

Our battles are not a stain on the doctor's reputation but a protection of it. The false accusations of unnecessary surgery, the rest of the constant fusillade of abuse and the flood of intimidating legislation and regulation are all part of a pattern. And that pattern has to be broken, or else medicine will lose its own pattern. So with all the vigor of reason and fact, we have countered the fabrications about unnecessary surgery, other daily lies, and the Federal Trade Commission complaint, which would debase medicine with the gimmickry of all-out advertising. It is easy to be dismayed by all the criticism. But it is nothing new. People throughout history have mocked our calling partly as a way of laughing at life and the fear of death.

Now that medicine is a science, it should be less derided. Yet, we must realize that it will never catch up with all the illusions it can inspire or live down all the fears it can provoke. Yes, we will be criticized. Still, the public opinion polls show that we are cherished—more so than any other calling. I firmly believe that in the dark thinking night of men's souls, we will continue to be cherished, and more so than ever before.

People will look to us because every advance against sickness and disease is only the prelude to a new challenge. They will look to us because the sorcery of science in artificially creating life, and prolonging it, will cry out to us for answers, ethical and spiritual answers as well as medical answers. We will be called upon to sit at the bedside of the meaning of life itself.

This federation, with its historic clinical orientation and its expanding ethical concerns, will help us physicians do that, even while it fights the indispensable battles of law and legislation. Throughout this federation, our identity as doctors will endure and expand. So I assume your Presidency with courage for the future. I assume it with reasonable hope. I have moments when hope flickers but I have far more reassurances.

And one of those reassurances comes from a man who was a plantation owner in Old Virginia at a time when smallpox was a scourge. This man was keenly aware of the smallpox vaccine developed by Edward Jenner. He took the lead in introducing it to Virginia and America. He learned how to safeguard the potency of the virus and make innoculations. And as days went by on his plantation and up and down the river and hills, he saw life bloom without the age old scourge.

Taking time from his duties as President of the United States, he wrote Doctor Jenner a letter that closed with these lines: "You have erased from the calendar of human afflictions one of its greatest. Yours is the comfortable reflection that mankind can never forget that you have lived. Future nations will know by history only that the loathsome small-pox has existed and by you has been extirpated. Accept my fervent wishes for your health and happiness and assurances of the greatest respect and consideration."

Let me be so bold as to suggest that this letter signed "Thomas Jefferson" is a message to all of us. It is an exhortation to all of us "to strive, to seek, to find, and not to yield," to walk tall against the night, and to see, beyond the night, the morning star. It is an affirmation for you and for me particularly in this Bicentennial Year. For this federation, this federation of ours, is the Independence Hall of Medicine. And by the grace of all of you and all of our members, its bell keeps ringing! ▬

Viral Hepatitis During Pregnancy

Gary L. Smith, MD, Larry C. Gilstrap III, MD, and
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Eight patients with coexisting pregnancy and hepatitis are presented, two with associated heroin usage. The effect of hepatitis and pregnancy on each other is shown to be minimal in a population with good nutritional and socioeconomic standards.

THE INCIDENCE of viral hepatitis is rising in America, with teenagers and young adults increasingly affected; this was noted in a recent review in this journal of the general characteristics of viral hepatitis.[1] Additionally, the proportion of pregnancies in this group is increasing; thus it is often the obstetrician, as the primary care physician, who is managing both pregnancy and hepatitis. At Wilford Hall USAF Medical Center, eight cases of viral hepatitis complicating pregnancy have been managed and form the basis of this report.

MATERIALS AND METHODS

Records of consecutive deliveries from January, 1970, to December, 1974, were reviewed. The majority of the obstetrical population consisted of patients who were well nourished, cooperative, young, white and of low parity. Those patients with a clinical diagnosis of hepatitis confirmed by abnormal liver function tests were evaluated as to the course of the pregnancy. Maternal serum and cord blood for hepatitis associated antigen (HB_sAg) were obtained.

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The opinions expressed in this manuscript are those of the authors and not necessarily those of the US Air Force or the Department of Defense.

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RESULTS

From 1970 through 1974, viral hepatitis was diagnosed for eight of 8,762 delivered patients (0.092%). The age, race and parity for these eight patients are representative of the general population (Table I). One patient signed out of the hospital against medical advice during the acute episode and subsequently developed acute pyelonephritis with delivery at 35-weeks gestation. A history of drug abuse was obtained from two patients. The onset of hepatitis occurred during the third trimester for six patients.

The clinical course of hepatitis and pregnancy in each patient was benign. There was no maternal or perinatal mortality and no significant morbidity for mother and infant. For seven infants the results of HB_sAg testing was recorded. Two infants (29%) were HB_sAg positive. Two other infants were noted to have mild abnormalities of liver functions which rapidly reversed to normal.

DISCUSSION

The incidence and prognosis of hepatitis has been shown by epidemiological studies to be related to

Table I. Summary of Eight Patients with Hepatitis During Pregnancy

patient by age	race	parity	trimester of pregnancy at onset	length of gestation (weeks)	maternal Hb_sAg	cord blood Hb_sAg	history of parenteral drug abuse
18	W	0000	third	37	pos	neg	none
19	W	0000	at conception	40	pos	pos	yes
20	W	2002	first	41	*	*	yes
22	W	0000	third	37	neg	pos	none
22	B	2002	third	35	neg	neg	none
24	W	0020	third	38	neg	neg	none
26	W	2022	third	37	neg	neg	none
32	W	2002	third	38	neg	neg	none

*Not recorded

social and economic factors, the general health and nutrition of the population involved and the virulence of the infecting virus. In studies of populations of the indigent poor, the incidence of hepatitis is quite high, with resultant high morbidity and mortality. Furthermore, the incidence of hepatitis complicating pregnancy and the incidence of maternal mortality are increased. D'Cruz[2] reported 77 maternal deaths in 143 patients with hepatitis during pregnancy (54%), as contrasted to a 26% mortality among nonpregnant females of childbearing age. Hepatitis was associated with 20% of all maternal mortalities and was the largest single factor for maternal mortality in his population. Borhanmanesh[3] similarly reported that pregnancy seemed to affect adversely the outcome of hepatitis, with a higher incidence and increased mortality. He suggested that the severity increased if the acute phase of hepatitis began in the third trimester, possibly due to nutritional demands and hormonal influences. Jones and Cohen[4] demonstrated experimentally that estrogens exert a deliterious effect on the anatomic lesions, enzyme activity and clinical course in severe hepatitis.

In contrast to these reports, Adams et al[5] reported only one maternal death in a group of 34 patients with pregnancy-associated hepatitis from an urban poor population of the American southwest. In the present analysis, in six of the eight patients the onset of hepatitis occurred during the third trimester, and there were no maternal mortalities. Thus, in a popu lation where nutritional and socioeconomic stand ards are generally good, pregnancy does not appea to alter the course of hepatitis.

In the D'Cruz and Borhanmanesh studies, ther were significant increases in spontaneous abortions stillborns and premature deliveries, with a resultan increase in perinatal morbidity and mortality. How ever, Adams reported the incidence of fetal wastag in pregnancies complicated by hepatitis to be simila to the general population. In the present series, ther was no evidence that hepatitis had altered the out come of the pregnancy.

Current studies indicate that the placenta is a bar rier to the transmission of HB_sAg; however, trans placental passage has been reported occasionally[6]- Merrill et al[10] indicate that when the mother is symptom-free HB_sAg carrier, passage of the vira antigen to the fetus can occur but does not necessaril result in fetal hepatic disease. All HB_sAg positiv infants in his study were delivered of mothers wit active hepatitis about the time of birth. The preser data also demonstrates that placental transmission c HB_sAg may occur. Of the two HB_sAg positive in fants, active maternal hepatitis was present just pric to delivery for one patient and at conception for on patient.

Stevens et al[6] have shown that approximately 40 of infants born to asymptomatic HB_sAg-carrie

omen also become antigen carriers. Furthermore, e probability that the baby will become a carrier is rectly related to the mother's antigen titer. They pothesized that transmission usually occurs ound the time of labor and delivery. Although ansmission via breast milk is biologically possible ince HB_sAg has been demonstrated in breast milk carrier mothers), studies have shown no difference the frequency of antigenemia among breast-fed d non-breast fed infants.[6,11]

Newer concepts concerning the epidemiology of ral hepatitis are being accepted. Both hepatitis A d B can be transmitted parenterally and non-renterally.[12-14] Positive screens for HB_sAg have een found in saliva, urine, feces and semen. The crease in parenteral drug abuse as well as the appar-t increase in promiscuity and multiple consorts in a gnificant proportion of the younger age group is a otential source of venereal epidemic spread of hepa-tis.

It is important that the pregnant woman with epatitis be diagnosed and treated long before she ecomes moribund. The gravida with early or mild necteric hepatitis and early mild gastrointestinal symptoms may be considered normal for early pregnancy. Undoubtably, occasional cases of hepatitis are missed because of this assumption. As a result, supportive treatment may not be instituted until the mother is gravely ill. Furthermore, the development of these symptoms subsequent to the early weeks of pregnancy must be evaluated critically.

The regimen for treatment of hepatitis during pregnancy consists of hospitalization, bed rest and a good diet. Parenteral fluids and nutrition should be provided if serious vomiting occurs.

The obstetrician may be the only physician seen by the susceptible gravida. If the diagnosis is to be made, appropriate management rendered, and proper followup evaluation of the mother and infant is to be achieved, the obstetrician must be acutely aware of the population at risk and the possibility of coexisting hepatitis and pregnancy.

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(Continued next page.)



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Virginia Physicians Now Have Their Own Recognition Award

A new Virginia Physician Recognition Award, designed primarily for members of The Medical Society of Virginia, has been established by the Society's Commission on Continuing Medical Education. The award will honor physicians who complete 150 hours of continuing education over a three-year period beginning July 1, 1973, or any time thereafter. A handbook detailing all requirements for the award will go into the mail to Society members soon.

Application for the award is voluntary. A physician working in any specialty can qualify. Criteria are compatible with other similar programs. A record book in which the physician may log his CME activities has been printed and is available on request from the Society's Continuing Medical Education office. The office also will supply the summary sheet with which the physician must apply for the award.

To qualify for the award, a physician must accumulate 150 credit hours in CME activities meeting the educational requirements formulated by the American Medical Association for its Physician Recognition Award and identified in six categories: 1. CME activities with accredited sponsorship. 2. CME activities with nonaccredited sponsorship. 3. Medical teaching. 4. Papers, publications, books and exhibits. 5. Nonsupervised individual CME. 6. Other meritorious learning experiences. In Category 1, the applying physician must show at least 60 hours, and there is no maximum limit. But in Category 4, no more than 40 hours may be listed, and in the other categories, no more than 45 hours.

Members of the Commission are **Charles E. Davis, MD,** *Norfolk,* chairman; **William F. Bernart, MD,** *Nassawadox*; **George J. Carroll, MD,** *Suffolk;* **Charles L. Crockett, Jr., MD,** *Roanoke;* **Charles H. Crowder, Jr., MD,** *South Hill;* **T. Winston Gouldin, MD,** *Norfolk;* **Hannibal E. Howell, Md.** *Hampton,* **Harry C. Kuykendall, MD,** *Alexandria;* **Melvin D. Small, MD,** *Alexandria;* **Clarence Taylor, MD,** *Shawsville;* **Oscar A. Thorup, Jr., MD,** *Charlottesville;* **David B. Walthall III, MD,** *Richmond;* **Bruce J. Innes, MD,** *Norfolk.*

Supracondylar Fractures

Arthur A. Kirk, MD, and William Herndon, MD, *Portsmouth, Virginia*

In ten cases of supracondylar fracture of the elbow treated by crossed irschner wire fixation, superior results were obtained by open reduction and ıternal fixation.

NUMEROUS METHODS of treatment of supracondyır fractures of the humerus in children have been escribed. Frequently used are closed reduction and nmobilization in flexion, reduction and immobilizaion in extension, skin traction as described by Dunop,[1] overhead traction with an olecranon pin, perutaneous crossed Kirschner wire pinning, and open eduction and internal fixation with crossed Kirschıer wires. No one method has proved to be free from omplications. In our experience, treatment in tracion has proven to be successful in preventing circuatory problems and late results have generally been atisfactory. However, this treatment often requires everal manipulations, frequent traction adjustments ınd a hospital stay of two to four weeks. In severely lisplaced fractures with marked swelling, crossed Kirschner wire fixation of this fracture, either percutaneously or by open means, greatly simplifies reatment of this condition.

We have treated ten patients in this manner. The following are illustrative cases.

CASE REPORTS

Case 1.

This 11-year-old white female fell on her outstretched right arm with resultant severe pain and deformity of her forearm and elbow. She was found to have a displaced supracondylar fracture of her humerus and minimally displaced fractures of the middle one-third of her radius and ulna. She was taken to the operating room where closed reduction and percutaneous crossed Kirschner wire fixation of her elbow fracture was performed. Her forearm fractures were reduced and casted. Approximately six weeks later the cast and pins were removed and range of motion was begun. At last followup, one year after her injury, she had a normal carrying angle with a range of motion which lacked ten degrees of extension and five degrees of flexion. She had normal supination and pronation of her forearm.

Case 2.

This 7-year-old white female fell from a swing, landing on her outstretched right arm. There was marked swelling and pain about the elbow with numbness over a median nerve distribution in the hand. Roentgoenograms revealed a posteriorly displaced supracondylar fracture of the humerus. She was taken to the operating room where an open reduction of the fracture was performed. The fracture was fixed with two crossed Kirschner wires. At the time of surgery, the median nerve was removed from the tip of the proximal humeral spike. Two years after injury, the patient had a normal range of motion of her elbow with a normal carrying angle. Median nerve function was normal.

Case 3.

This five-year-old white female fell on her right arm while running. Evaluation revealed a posteriorly displaced supracondylar fracture with no motor, sensory, or circulatory deficit in the extremity. She was taken to the operating room where closed reduction and percutaneous Kirschner wire fixation was performed. Postoperatively she was found to have a complete ulnar nerve palsy. When her pins were removed, the range of motion of her elbow was normal. Ulnar nerve function returned satisfactorily.

Case 4.

This four-year-old white male sustained severe pain, swelling and deformity of his right elbow after falling and

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landing on his outstretched arm. He was found to have a posteriorly displaced supracondylar fracture of his humerus and was taken to the operating room where an open reduction and internal fixation of the fracture with two crossed Kirschner wires was performed. Three months after surgery, he had a normal carrying angle and a range of motion which lacked ten degrees of extension.

DISCUSSION

Severe swelling, vascular compromise and nerve injury are initial complications of this fracture. Vascular problems usually improve following reduction of the fracture. Injuries to the nerves crossing the elbow usually recover spontaneously. Loss of elbow motion, change in carrying angle and myositis ossificans may be seen after fracture healing has occurred and are usually related to the severity of the initial injury and to the final reduction achieved. Cubitus varus deformity is probably due to late medial tilt or rotation of the distal fragment and prevention of this should prevent this deformity.[2]

In the mid-1940's, Scandinavian authors described good results with open reduction of these fractures.[3,4] In 1964, Gruber and Hudson[5] described 31 supracondylar fractures treated by open reduction and Kirschner wire fixation with good results. The incidence of late cubitus varus deformity was less than 10% and loss of motion included mild losses of extension only. There were no vascular or neurologic complications. There was one superficial infection.

Jones[6] and later Haddad et al[7] advocated closed reduction and percutaneous pinning of these fractures. Pin insertion was performed with minor difficulty and post-operative complications were minimal. No fracture lost reduction and there were no infections. No late growth disturbances were reported.

Of the ten cases in this report, five were opened and five were fixed percutaneously. Long-term followup was lost in one of the cases treated openly and in two cases treated closed. The remaining four children treated by open reduction and internal fixation had excellent results, with minimal or no loss of elbow motion and no change in carrying angle. One case with percutaneous fixation had an excellent long-term result. The last case treated in this manner is four months post injury. She sustained an ulnar nerve palsy during the procedure, which has shown good signs of recovery over this period of time. The range of motion and carrying angle are normal.

Open reduction in all instances was carried out through a lateral incision and did not prove difficult. In one case an additional medial incision had to be made because of interposed soft tissue on that side. Percutaneous pinning of these fractures in some cases proved to be difficult. Numerous attempts were sometimes required for proper placement of the pins and the one case of ulnar nerve injury can be attributed to this. When the fracture was opened, the initial pin was drilled from the lateral epicondyle into the humeral shaft under direct vision and medial pin was placed percutaneously. This was much easier than placing both pins by palpation alone. The procedure is made easier using a motor drill or "squeeze" type of drill in one hand while controlling the fracture with the other. Drains were frequently placed for two days.

No case treated by either method lost position postoperatively. There were no infections and myositis ossificans did not occur. The usual stay in the hospital was two to five days.

SUMMARY

Ten cases of supracondylar fracture of the elbow treated by crossed Kirschner wire fixation were studied. Five patients were pinned openly and five percutaneously. Percutaneous Kirschner wire insertion at times was difficult and one ulnar nerve injury resulted. Results of those cases treated by open reduction and internal fixation were excellent, agreeing with earlier literature. Open treatment allows exploration of any nerve or vascular deficit and drainage of the hematoma. It has been a satisfactory method of treatment in our experience in those cases with marked swelling and severely displaced fractures. Percutaneous pin fixation is preferable when the fracture can be reduced easily and swelling is not yet extensive.

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Sixteen months after supracondylar fracture of the right humerus, displaced, the patient demonstrates essentially normal extension. Surgical procedure included open reduction of the fracture, fixation with two crossed Kirschner wires and removal of the median nerve from the tip of the proximal humeral spike.

Solitary Cold Nodules Of The Thyroid Gland

Ira D. Godwin, MD, *Fairfax, Virginia,* and
Eva L. Mikhail, MD, *Falls Church, Virginia*

A study of 100 patients reports the incidence of solitary cysts, adenomat adenomatous goiter and malignant tumor in relation to solitary cold nodules the thyroid.

MUCH HAS BEEN WRITTEN about the incidence of malignancy in solitary cold nodules of the thyroid detected by radioactive iodine scanning.

In 1954 Perlmutter et al[1] reported that the incidence of cancer was 32% in solitary cold nodules of the thyroid. In 1962 Meadows[2] reported an incidence of 55%. Johnson and Beierwaltes[3] in 1955 found an incidence of 31%. Dobyns[4] in 1949 described an incidence of 18%. Greobeck[5] in 1959 reported a 14.2% incidence. In spite of the wide statistical range between Meadow's and Groesbeck's studies, all authors seem to agree that most of the malignant tumors of the thyroid have less than normal functional capacity as seen by radioactive iodine scan.

It is also well recognized that the iodine-concentrating ability is decreased or absent in adenomas. The same is true in tumor-like lesions, including adenomatous goiter and Hashimoto's thyroiditis. Uptake may be decreased by hemorrhage, necrosis, degeneration and cyst formation. This study was undertaken to correlate histopathological finding with solitary cold nodules of the thyroid gland a determined by scanning with radioiodine.

From the Fairfax Hospital, Falls Church (Dr. Mikhail), and Northern Virginia Pathology Laboratories, Fairfax (Dr. Godwin). Address communications to Dr. Godwin, 11091 Main Street, Fairfax VA 22030.

Presented at the Annual Meeting of The Medical Society of Virginia, Roanoke, Virginia, October 23-26, 1975.

MATERIALS AND METHODS

A retrospective study of 100 consecutive patient who had solitary cold nodules on thyroid scan an who underwent subsequent thyroid surgery at th Fairfax Hospital in Falls Church, Virginia, durin the five years from 1970-1975 was undertaken. Th cases were divided into these four histopathologica groups as defined by the Armed Forces Institute o Pathology[6]: solitary cysts; benign tumors (adeno mata); tumor-like lesions (adenomatous goiter); ma lignant tumors. Age and sex incidence was als studied.

RESULTS

Cold nodules were found to be more common i females than males with a ratio of 4:1. The ag incidence was between 17-71 years irrespective of th nature of the lesions. The mean age was 42 years.

Of solitary cold nodules of the thyroid, 8% wer solitary cysts (6 females, 2 males); 55% were benig tumors, i.e., adenomata (47 females, 8 males); 27 tumor-like lesions, i.e., adenomatous goiter (22 fe

ales, 5 males) and 10% malignant tumors (6 female, male).

DISCUSSION

The 10% incidence of cancer in solitary cold nodules is, in our estimation, significant and should warant a careful clinical followup.

Although cold nodules were found to be more ommon in females than males with a ratio of 4:1,

SOLITARY COLD NODULES
of the
THYROID GLAND
(Histopathology and Scan Comparison)

%	SOLITARY CYSTS	6 Females - 2 Males
5%	BENIGN TUMORS (Adenomata)	47 Females - 8 Males
	Embryonal	5%
	Fetal	20%
	Simple	5%
	Colloid	23%
	Oxyphilic	1%
	Atypical	1%
27%	TUMOR-LIKE LESIONS (Adenomatous Goiter)	22 Females - 5 Males
10%	MALIGNANT TUMORS	6 Females - 4 Males
	Papillary Ca	8%
	Follicular Ca	1%
	Medullary Ca	1%

the incidence of associated carcinoma in males is considerably higher than females, 4 out of 19 or 21%, as compared to 7.4% in females (6 out of 81 cases). It is approximately three times as frequent in males.

Due to the relatively small number of lesions, statistical conclusions might be inappropriate; however, careful consideration in the management of male patients with solitary cold nodules of the thyroid seems indicated. Regardless of the age or sex of the patient, the presence of a solitary cold nodule of the thyroid is significant.

SUMMARY

In this retrospective study:
- 10% of solitary cold nodules of the thyroid were histologically malignant;
- the other 90% were benign lesions including solitary cysts, adenomas and tumor-like lesions;
- in males the incidence of malignancy in solitary cold nodules is about three times that of females.

MEAN AGE AND RANGE OF
DIFFERENT HISTOPATHOLOGIC TYPES

	MEAN AGE	AGE RANGE
SOLITARY CYST	44 yrs.	28-55 yrs.
BENIGN TUMORS	35 yrs.	18-62 yrs.
TUMOR-LIKE LESIONS	43 yrs.	25-71 yrs.
MALIGNANT TUMOR	44 yrs.	17-69 yrs.

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Fig. 1. Right eye, Case 1. Pedunculated capillary hemangioma of the conjunctiva. Lesion measured 5 × 5 × 3 mm and caused repeated episodes of dacryohemorrhea.

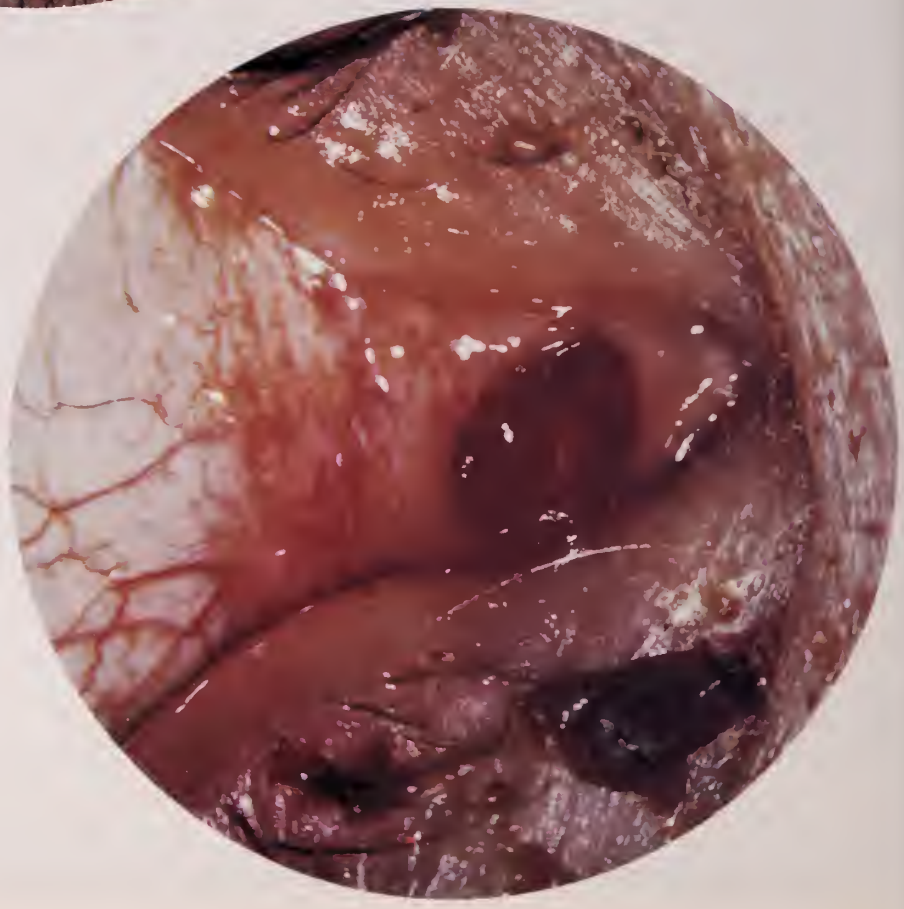


Fig. 2. Right eye, Case 2. Papilloma of the caruncle. Bright red color of lesion is due to hemorrhage, which also resulted in "bloody tears." Note the clotted blood on the lower eyelashes and cheek.

Dacryohemorrhea: The Phenomenon of Tears of Blood

Khalid J. Awan, MD, *Norton, Virginia*

Three unusual cases of free bleeding from conjunctiva in the absence of rauma are discussed, and causes of this alarming disorder are cited.

FREE BLEEDING from conjunctiva in the absence of ıny trauma is seen in only a few rare disorders. Clinically, the individual suffering from dacryohemorrhea appears to be literally weeping blood. The "bloody tears" appear spontaneously and are usually accompanied by little discomfort. This rather startling phenomenon is not to be confused with the sanious discharge commonly seen in acute infections and inflammations of the conjunctiva. However, isolated cases of conjunctivitis in anemic or cachectic individuals may show alarming conjunctival bleeding.[1]

Ocular causes of dacryohemorrhea as cited by Duke-Elder include the isolated cases of conjunctivitis, vascular tumors, manipulation of the conjunctiva, atheroma and idiopathic conjunctival bleeding in apparently healthy individuals. The purpose of this paper is to discuss the occurrence of dacryohemorrhea in three unusual cases.

CASE REPORTS

Case 1.

A 50-year-old white male was referred by the medical officer of the local county fair with complaints of sudden painless bleeding from the right eye. Two days prior to his visit he had been rushed to a nearby medical center because of a similar episode, but he had been given no treatment since the bleeding stopped spontaneously before he reached there. Eye examination showed healthy eyes except for a smooth, rounded, somewhat flattened and pedunculated red mass in the upper temporal fornix (Figure 1). Diagnosis of conjunctival papilloma or hemangioma with dacryohemorrhea was made. Because of the extreme nervousness of the patient, it was considered wiser to postpone the excision of the lesion for a few days, and he was started on eye drops four times a day. Two days later on the followup visit he reported the interesting fact that the lesion had spontaneously fallen off while he was taking a shower.

Three months later he returned with another episode of conjunctival bleeding. The right eye was full of fresh blood, and strings of clotted blood were present on the eyelashes and in the inferior fornix. He also stated that his nasal secretions and saliva were tinged with blood. On eversion of the upper lid the recurrence of the lesion was discovered. It was excised and submitted to the Ophthalmic Pathology Branch of the Armed Forces Institute of Pathology, Washington, for histopathologic studies. There it was reported to be a capillary hemangioma of the conjunctiva. No recurrence has been reported by the patient. The patient was systemically healthy and his laboratory blood studies were normal.

Case 2.

A 19-year-old white female was seen with the complaint of "bleeding from her right eye and blood running down her cheek" since the previous night. Bleeding was painless, and there was no history of any trauma. Eye examination was normal excepting a bright red pedunculated mass on the right caruncle (Figure 2). Some clotted blood was also present on the eyelashes and right cheek. The mass was approximately $4 \times 4 \times 3$ mm in size and bled easily on manipulation. The patient also reported that approximately two months previously she had been treated with eye drops for similar complaints. Two days later the lesion was excised. At the time of excision the color of the lesion had changed to greyish pink, and several small blood vessels could be easily noticed in it. Histopathologic studies confirmed the diagnosis of a benign papilloma. No recur-

From the Norton Community Hospital, Norton, VA 24273.

Funded in part by the Wise County Medical Society.

Presented in part at the Continuing Medical Education Staff Meeting of Wise Appalachian Regional Hospital, Wise, Virginia, May, 1976.

Submitted 5-12-76.

rence has been noticed. The patient was systemically healthy and blood studies were normal.

Case 3.

A two-week-old white female infant was seen because the parents complained of "blood running out of both her eyes." Mother stated that a week after birth the child's eyes became red and developed yellowish discharge. Her pediatrician was treating the baby with eye ointment every six hours in both eyes. However, the condition went on deteriorating and the night before the examination both eyes had started bleeding spontaneously. Eye examination disclosed swollen red lids with blepharospasm and the fresh blood trickling through all the canthi (Figure 3). Conjunctival sacs were full of red blood and strands of clotted blood were present in the inferior fornices. Corneas, pupils, anterior chambers and fundus reflexes were normal. After the blood was irrigated, marked papillary hypertrophy with a few small patches of pseudomembrane was noticed in the palpebral conjunctiva of both eyes. Smears and cultures for bacteria were negative and no inclusion bodies could be demonstrated. Condition showed improvement with sodium sulfacetamide (Sulamyd) treatment, but the final disposition could not be determined because the patient failed to return after two followup visits.



Fig. 3. Right eye, Case 3. Inclusion blennorrhea with dacryohemorrhea. Note the pool of blood in the medial canthus and blood trickling from lateral canthus. Both eyes were equally involved, and bleeding was alarming.

COMMENTS

Dacryohemorrhea is an alarming situation for both the patient and the physician. Indeed, Duke-Elder cites several instances in which the blood loss reached serious proportions. It appears reasonable that a thorough blood workup and a close followup of the patient for a certain length of time is indicated in every case of dacryohemorrhea even after a successful immediate treatment of the presenting source of bleeding. Site of free bleeding is almost always the palpebral conjunctiva, because any extravasation under it is not possible. In the bulbar conjunctiva, on the other hand, the hemorrhage remains subconjunctival and is finally stopped by pressure. It is important to remember that systemic disorders such as hemophilia, vicarious menstruation, jaundice, hysteria, disturbances of autonomic nervous system, etc., may be responsible for conjunctival bleeding in some cases.[1] Also, the possibility of bleeding from the lesions of lacrimal gland and regurgitation of blood from nose via the nasolacrimal passages should be explored. For a nice review of the subject the reader is referred to Duke-Elder.

Pedunculated tumors of the conjunctiva are not common and reports of pedunculated hemangiomas are even rare.[2] Association of repeated dacryohemorrhea with the pedunculated conjunctival hemangioma in Case 1 is even more interesting. This case also shows that a spontaneous cure of such hemangiomas is possible but may be followed by recurrence. This vascular tumor may be difficult to differentiate both clinically and histopathologically, from granuloma pyogenicum. Indeed, to some reviewers the histopathologic features of Case 1 suggested that the lesion might be granuloma pyogenicum. Some authors[3] think that granuloma pyogenicum is probably an angioma with superimposed secondary irritative or infective process. Both of these lesions, however, may be successfully treated by a proper local excision.

Papillomas of the conjunctiva are uncommon lesions, but as far as this author could determine, the papilloma of the caruncle has not been previously incriminated in causing dacryohemorrhea. Trauma to the lesion during sleep might be the probable mechanism in Case 2. It is important to point out that the benignity of the papillomata has been rather overemphasized. Since malignant changes are possible, the papillomata should be treated by an early and relatively wide excision. It must be remembered, however, that recurrences may occur, and at times these are multiple. Although possible, the multiple recurrences do not indicate a cancerous change.

In Case 3 the earlier history, the time of onset, the clinical findings, negative smears and cultures for

acteria, therapeutic response and the course of the isease indicate that the diagnosis of inclusion blenorrhea in this case is a correct one. I believe that the ailure to demonstrate the intracytoplasmic inclusion odies was probably due to the less-than-optimum mear material. The repeated episodes of frank and pontaneous bleeding are rather unusual for inlusion conjunctivitis of the newborn. Unfortunately, udies could not be performed to learn of any hematologic disorders in this infant.

SUMMARY

Dacryohemorrhea, the phenomenon of tears of lood, is discussed. Its causes are mentioned and its occurrence in a 50-year-old white male with unilateral pedunculated capillary hemangioma of conjunctiva, a 19-year-old white female with papilloma of the caruncle of right eye and a two-week-old white female with bilateral inclusion blennorrhea is reported.

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THE PRESIDENT'S MAIL

YOUR PRESIDENT gets many letters. Among those of a general nature, complaints about doctors not filling out insurance forms are the most frequent. A recent letter from one of our friends in the state legislature was on this subject and was answered in this way:

The Medical Society of Virginia does get occasional complaints, usually from insurance companies, indicating that physicians are slow to fill out insurance forms. I am sure it is a problem that will continue indefinitely.

The amount of time required to do the paper work associated with practice has grown steadily in recent years, and when a physician is faced with having to neglect either his paper work or his patients, most of them elect to neglect the paper work. Also, I suspect that there is a subconscious element in that the physician feels that the insurance is a contract between the patient and the insurance company, in which he played no part but in which he is now asked to participate.

The patient and the insurance companies frequently say it only takes a minute to do an insurance form; in some cases this is literally so, but in most instances it takes a great deal of time to extract the required information and to make a decision as to the severity and degree of injuries. In many instances it takes longer to fill out the insurance form than to treat the condition for which the form is being completed. Despite these facts, we recognize that insurance forms are a necessary part of medical practice as it is organized today, and most physicians accept the extra paper work with grace.

We want to do what the public needs and requires, and if you or your constituents have a specific complaint, I will be glad to write to the physician personally.

Another recent letter from a man in the insurance business suggested that, since the failure of physicians to complete insurance forms is such a problem, someone should have the power to enforce the completion of insurance forms. The following is excerpted from my letter to him:

Most physicians go into the practice of medicine because they like to be independent and don't like to take orders. We do have the State Board of Medicine, which is a statutory disciplinary board that can bring physicians into line when they do anything that is unethical or against the law, but short of this, I do not think there is any power available to make a physician do something he does not want to do.

Raymond S. Brown, MD, President

Electrical Inhibition of Staphylococcus Aureus

S. D. Barranco, MD,
and G. Colmano, DVM,
Blacksburg, Virginia

THE IN VITRO ABILITY of weak electrical current (0.4-400 μamp) through silver electrodes to inhibit growth of bacteria with negligible toxicity has already been demonstrated.[1,2] The possibility of this occurring in vivo prompted this study.

MATERIALS AND METHODS

Silver pins, contaminated by dipping into a broth culture of *Staphylococcus aureus* (coagulase positive, penicillin resistant) were inserted through the femorotibial articulation into the intramedullary canal of the femur of both legs of 12 New Zealand rabbits, each weighing 3½-4 kg and anesthetized with intramuscular ketamine. A negative silver wire was used as a ground, anchored to the subcutaneous tissue of the inguinal region. The current from a resistor on the positive pole of a 1.35-volt battery delivering 75 μamp was connected to the silver pin on the right leg for one hour, so that a calculated output of six μamp was supplied (2 μamp per cm of silver electrode). The opposite leg was used as control, and no electrical current was supplied to it. Following electrical stimulation, the lower limbs were placed in plaster casts over sterile dressings to diminish the possibility of further contamination. The rabbits were sacrificed at one week, and the pins were removed and assayed for *S aureus* by plating the rods on agar pour plates and incubating these for 24 hours.

RESULTS

There was a marked inhibition of bacterial growth of those plates whose electrodes were treated by electrical stimulation (Figure 1). This was demonstrated by much lower or negative plate counts from the right or current-treated leg as compared to the left control leg. The clinical appearance of the wounds, lack of purulence in the treated side and histological studies (diminished inflammatory reaction) confirmed this inhibition.

CONCLUSIONS

Effective inhibition of the growth of *S aureus* in vivo by institution of weak electrical current through silver electrodes at the time of contamination can occur. Future studies to determine whether silver coating on stainless steel implants will work as well as pure silver are also indicated, as this could have practical application in animal and human operative procedures. Also, the mechanism of inhibition of growth of bacteria by electrical stimulation must be demonstrated. The possibility of applying electrical stimulation as an inhibitor of microorganism growth to other animals, including human, remains for future more extensive studies.

References

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2. Spadaro JA, Berger TJ, Barranco SD et al: Antibacterial effects of silver electrodes with weak direct current. Antimicrobial Agents in Chemotherapy, Nov 1974, p. 637

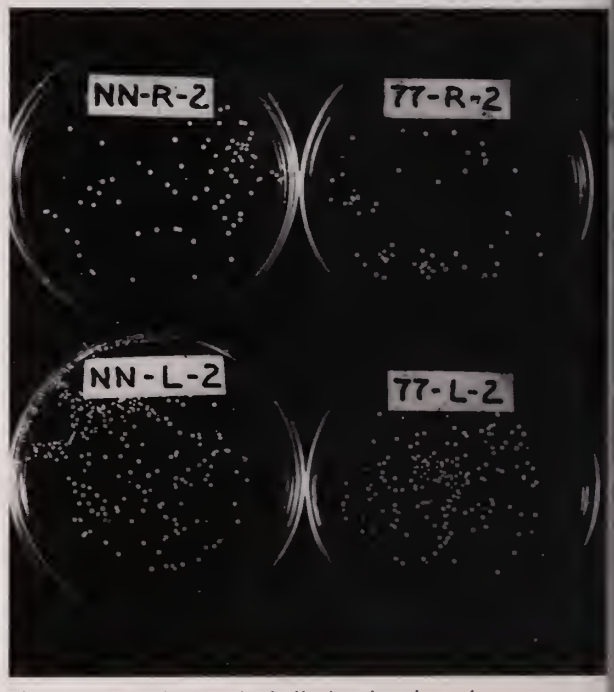


Fig. 1. Note the marked diminution in colony count on the electrically stimulated plates (R) versus those not stimulated (L).

From the Department of Orthopedic Surgery, Montgomery County Hospital, and the Department of Veterinary Science, VPI & SU, Blacksburg. Address Dr. Barranco, 104 Hubbard Street, Blacksburg VA 24060.

Submitted 1-6-76.

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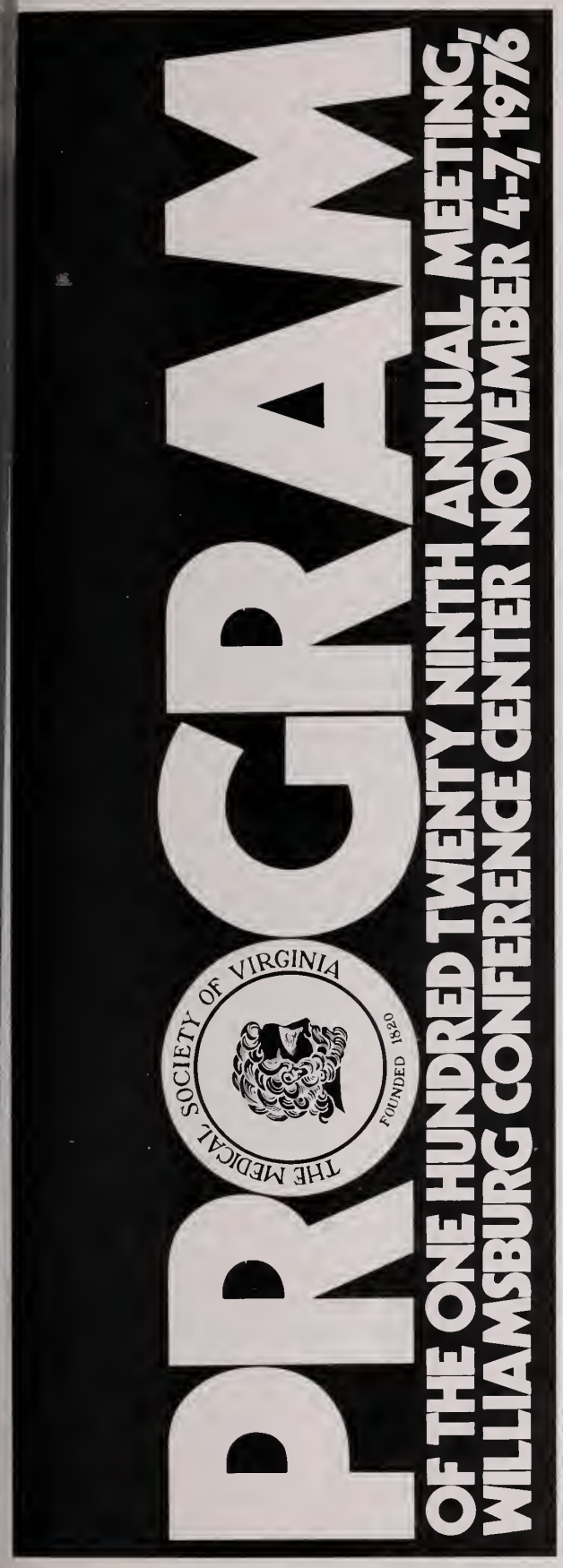
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Sessions of the Society

Thursday, November 4

10 am
Council — *Room C*

2 pm
House of Delegates — *Virginia Room*

Friday, November 5

2 pm
Reference Committee 1 — *Room A*

Reference Committee 2 — *Tidewater Room*

Reference Committee 3 — *Auditorium*

Saturday, November 6

2 pm
House of Delegates — *Tidewater Room*

6:30 pm
The Medical Society of Virginia Reception — *North Gallery*

7:30
Banquet — *Virginia Room*

Sunday, November 7

9 am — *Auditorium*

Panel on Public Law 93-641, National Health Planning Act. Sponsored by the Virginia Society of Internal Medicine.

THIS PRESENTATION will cover the specifics and implications of this law as well as physician reaction.

10 am — *Auditorium*

Panel on Negotiation.

SEVERAL POINTS OF VIEW of this important subject will be covered in this presentation, which is given in cooperation with the American Medical Association. The panel is being arranged by a special committee appointed at the direction of the House of Delegates.

Scientific Session A

Friday, November 5

Auditorium

9 am

Welcome and Preliminary Announcements. Arthur A. Kirk, MD, Chairman, Committee on Arrangements.

Blood Component Therapy, a Two-Year Study in a Large Community Hospital. Eva Mikhail, MD, and C. Barrie, Cook, MD, *Falls Church.*

A TWO-YEAR STUDY of blood component therapy in a community hospital was undertaken. The study emphasizes the intelligent utilization of the various blood components and the need for determining the patient's blood deficit and for transfusing accordingly. The use of blood component therapy in relation to different disease entities will also be discussed.

9:15 am

Reliability and Usefulness of Graded Exercise Electrocardiographic Testing for Diagnosis of Ischemic Heart Disease. Hugh B. McCormick, MD, John A. Horgan, MD, and John P. Jones, MD, *Newport News.*

GRADED EXERCISE electrocardiographic testing (GET) has proved of increasing benefit in the diagnosis of cardiac ischemia. The data from over 1,300 GETs performed in a teaching hospital are reviewed. When correlated with coronary angiography, they emphasize reliability, safety and usefulness in community clinical practice.

9:30 am

Tetralogy of Fallot: Long-Term Assessment Following Complete Surgical Correction. Louise W. Robertson, MD, H. Page Mauck, Jr., MD, Jon B. Tingelstad, MD, and Carolyn M. McCue, MD, *Richmond.*

CLINICAL, hemodynamic and electrophysiological evaluation was carried out in 50 patients with tetralogy of Fallot 45 months after complete surgical correction, and the findings are documented. Forty-one patients were asymptomatic at followup; those with symptoms are described. The long-term status following complete surgical correction is usually excellent.

9:45 am

Transthoracic Low-Energy Defibrillation of the Human Ventricles. Richard S. Crampton, MD, and Frank P. Hunter, BEE, *Charlottesville.*

LOW DELIVERED energy, 2.2 joules/kg (only 33% of present recommended countershock dose), eliminated 16 episodes of ventricular fibrillation in nine coronary patients. Successful direct current countershock at lower risk of heart burn was provided by an inexpensive 3.6-kg miniature defibrillator, by 5- and 12-msec pulse lengths and by rapid sequence shocks.

10 am

When Does Renal Arterial Disease Mean Renovascular Hypertension? J. A. Grossman, MD; H. A. Wellons, Jr., MD; E. D. Vaughan, Jr., MD; R. M. Carey, MD; C. R. Ayers, MD; C. J. Tegtmeyer, MD, *Charlottesville.*

THIRTY HYPERTENSIVE patients with renal arterial disease have been evaluated preoperatively using, 1) renal vein renin ratios; 2) differential renal vein renin to arterial renin relationships and peripheral plasma renin activity indexed against 24-hour sodium excretion; or 3) the angiotensin II inhibitor, 1 Sar-8 Ala angiotensin II. All patients have undergone renal artery revascularization and have been followed for at least six months postoperatively. The relative value of the above parameters in predicting surgical curability will be discussed.

10:15 am

A Ten-Year Followup of the Kidney Transplant Patient. H. M. Lee, MD, *Richmond.*

THIS STUDY documents 102 patients who underwent renal transplants, with ten-year followup. Sixty-six patients received kidneys from living-related donors, 32 from cadaver donors and four from living-unrelated donors. All long-term survivors have good graft function with 80% normal renal function.

10:30 am

Recess for Coffee in the Exhibit Hall, *North Ballroom, lower level.*

11 am

Panel on Breast Cancer. Sponsored by the American Cancer Society, Virginia Division.

FIVE SPEAKERS will update the subject with regard to surgical approach, hormonal therapy, radiotherapy and chemotherapy. There will be a 30-minute question and answer session.

12:30 pm

Adjourn.

Scientific Session B

Friday, November 5

Tidewater Room

9 am

Improved Patient Followup Utilizing a Letter Reappointment System. George W. Vetrovec, MD, *Richmond.*

TO DECREASE clinic dropout rates, followup letters were sent to those patients missing a regularly scheduled appointment over a ten-month period. The results showed 69.6% (32/46) return patient visits, markedly reducing the 21.7% dropout rate for routine appointments. Thus, letter reappointments mailed to dropout patients are a simple, effective means of improving patient followup.

9:15 am

Diagnosis and Treatment of Benign and Malignant Lesions of the Face. James H. Carraway, MD; Charles E. Horton, MD; Jerome E. Adamson, MD; John B. McCraw, MD; Leonard A. Sharzer, MD, *Norfolk.*

THERE ARE many benign lesions which may enlarge progressively and because of their appearance and symptoms may mimic malignant problems of the skin. Emphasis in this paper will be on diagnosis of skin lesions, methods of removal of simple lesions, technique used for complicated lesions and new methods of reconstruction available to the plastic surgeon today.

9:30 am

Hypersensitivity as a Cause of Dermatological and Vaginal Moniliasis Resistant to Topicals. Henry J. Palacios, MD, *McLean.*

EIGHTEEN CASES of chronic or recurrent dermatologic or vaginal moniliasis were considered as allergies because of their high rate of improvement by desensitization and their frequent association with skin and respiratory allergies. Xerosis and seborrhea sicca (not usually considered allergies) and perennial allergic rhinitis were the most frequent hypersensitivities encountered.

9:45 am

Panel on Alcoholism. David G. Fluharty, Jr., MD, will discuss the early diagnosis of alcoholism. The Panel will then address the topic of treatment facilities over the state.

10:30 am

Recess for Coffee in the Exhibit Hall, *North Ballroom, lower level.*

11 am

Relicensure Recertification. Guest Speaker, Warren H. Pearse, MD, Executive Director, American College of Obstetricians and Gynecologists. Sponsored by the Virginia Obstetrical and Gynecological Society.

THE CALL for continuing competence of the physician is indirectly mandated by a number of federal documents, although there is no existing or proposed federal law which directly requires relicensure or recertification. A number of state licensing boards and state medical societies have initiated a mandatory continuing education requirement for maintenance of licensure or membership. The present state of requirements, the four possible approaches to continuing competence, and the experience with recertification by the American Board of Internal Medicine, together with proposed applictions to the specialty of obstetrics and gynecology, will be discussed.

11:30 am

Panel on Multiple Traumatic Injuries. Sponsored by the Virginia Chapter of the American College of Surgeons.

A MULTI-DISCIPLINARY session on the early management of patients with multiple traumatic injuries will be presented.

12:30 pm

Adjourn

Program Committee

John A. Owen, Jr., MD, *Charlottesville,*
Chairman
Jerome D. Skaggs, MD, *Hopewell*
Reuben B. Young, MD, *Richmond*
Alan G. Bartel, MD, *Virginia Beach*

Scientific Session A

Saturday, November 6

Auditorium

9 am

Interstitial Radiation Implants (I-125) as Treatment for Carcinoma of the Prostate. Paul F. Schellhammer, MD, *Norfolk.*

THE TECHNIQUE of interstitial implantation of the prostate with I-125 seeds for definitive treatment of carcinoma has several theoretical as well as practical advantages. The rationale for the procedure is described in light of past experiences with radical surgery and radiotherapy. The application of the technique in the treatment of 25 patients at Norfolk General Hospital will be reviewed.

9:15 am

Advances in Reconstructive Surgery of the Upper Urinary Tract. Warren W. Koontz, Jr., MD; M. J. Vernon Smith, MD; John H. Texter, Jr., MD, *Richmond.*

IN THE PAST ten years, there have been a number of advances in the surgical management of acquired and congenital obstructive lesions of the kidney and ureter. The results of such surgery are much improved and include a number of patients who previously had undergone "permanent" urinary diversion who may now be reconstructed.

9:30 am

Seminar on Urinary Tract Infections. Sponsored by the Virginia Urological Society.

FIVE SPEAKERS will discuss such topics as diagnosis, screening and home cultures; management of UTI in pediatrics; prophylactic UTI medication; news in antibiotics; management of infection.

11 am

Symposium on the Management of the Sick and Incompetent Physician. Robert C. Green, Jr., MD, *Winchester;* George J. Carroll, MD, *Suffolk;* and William D. Buxton, MD, *Charlottesville.* Raymond S. Brown, MD, Moderator.

THE TOPIC will be discussed with specific reference to procedures and mechanisms that should be employed at the local level. Typical case histories will be presented, followed by a discussion period.

12:30 p.m.

Adjourn.

Scientific Session B

Saturday, November 6

Tidewater Room

9 am

Dwarfing Syndromes Recognizable at Birth. Meinhard Robinow, MD, *Charlottesville.*

THE GREAT MAJORITY of dwarfing conditions can now be recognized at birth and can be diagnosed precisely by a combination of clinical assessment and radiography. Laboratory studies are rarely needed. Correct diagnosis is essential for interpretation of the handicap, prediction of adult stature and for genetic counseling. Examples will be shown.

9:15 am

Changing Survival Rates in the Use of Respiratory Support for Infants with Respiratory Distress Syndrome: Two Years of Experience. D. G. Mueller, MD, and B. V. Kirkpatrick, MD, *Richmond.*

RESPIRATORY DISTRESS syndrome (RDS) is a major cause of neonatal mortality. Mechanical ventilation and continuous positive airway pressure (CPAP) have improved mortality rates. We reviewed 272 patients with RDS treated over two years at the Medical College of Virginia. With each six-month interval survival improved, reflecting increased experience and improved techniques in the use of respiratory support equipment.

9:30 am

Rehabilitation Services in a Nursing Home Setting. Robert I. McClaughry, MD, *Alexandria.*

THE EFFECTS of setting up complete rehabilitation programs in two different nursing homes were observed. With the implementation of the programs, effects on nursing care, medications and discharge patterns were measured. Patient well-being improved, as did some parameters subject to quantification.

9:45 am

The Evaluation of Testicular Causes of Male Infertility. John F. Stecker, Jr., MD, *Norfolk*

MALE INFERTILITY accounts for 40-50% of barren marriages. Although 75% of infertile males will demonstrate abnormal testicular histology, the basic mechanism responsible for the altered testicular histology remains unknown. The Leydig and Sertoli cells are very important in maintaining spermatogenesis, and we have assessed these cells'

responsiveness in patients with oligospermia and azospermia in hopes of determining future treatment regimes.

10 am

Treatment of Impotence Through Hypnosis. Winfred O. Ward, MD, *Richmond.*

A SURVEY of 51 cases of impotence is presented. Hypnosis was the primary therapy with supportive consultation involving the sexual partner where indicated. Illustrative cases are presented along with means of therapy. A breakdown is made of incidence, age grouping, duration of therapy and results with followup.

10:15 am

Cholecystectomy: Experience in a General Hospital. Rahmat M. Seif, MD, *Roanoke.*

THE RESULTS of 779 cholecystectomies (1970-1974) at Roanoke Memorial Hospital revealed 1) 0.75% mortality; 2) 10% common duct explorations, with 61% of these having stones; 3) operative cholangiograms in 164 patients saved common duct explorations in 60% of them; 4) operative cholangiograms were negative when common duct stones were unsuspected clinically; 5) associated operations increased the mortality of cholecystectomy by tenfold.

10:30

Recess for coffee in the Exhibit Hall, *North Ballroom, lower level.*

11 am

Exciting New Developments in the Care of the Newborn. Sponsored by the Virginia Chapter of the American Academy of Pediatrics. F. Stanley Porter, MD, Moderator

1. **Regionalization and Transport.** Fred Wirth, MD, Director, Neonatal Intensive Care Unit, *Norfolk.*
2. **Respiratory Problems and Therapy.** John Katwinkle, MD, Director, Neonatal Intensive Care Unit. University of Virginia Hospital, *Charlottesville.*
3. **Problems in the Full-Term Newborn.** David Draper, MD, Director of Nursery, Medical College of Virginia, *Richmond*

12:30 pm

Adjourn

Specialty and Alumni Meetings

Thursday, November 4

American College of **Radiology,** Virginia Chapter
12 noon: Luncheon — *Room F*

VaMPAC
6 pm: Cocktails — *North Gallery*
7 pm: Banquet — *Tidewater Room*

Friday, November 5

VaMPAC Board of Directors
7:30 am: Breakfast — *Room D*

Virginia **Ob-Gyn** Society Executive Committee
7:30 am: Breakfast — *Room H*

American Association of **Public Health** Physicians, Virginia Chapter
7:30 am: Breakfast — *Room E*
Followed by Meeting

Virginia **Ob-Gyn** Society
1 pm: Luncheon — *Room B*

American **College of Physicians**
1 pm: Luncheon — *Rooms D and E*

Virginia **Orthopaedic** Society, Executive Committee
1 pm: Luncheon — *Room F*

International **College of Surgeons**
1 pm: Luncheon — *Cascade Convention Center Cascades 2*

Virginia **Flying Physicians** Association
6:30 pm: Cocktails — *Place to be announced.*

University of Virginia Medical Alumni Association
6:30 pm: Cocktails — *Residence of Dr. Janet Kimbrough, adjacent to Palace Green*

Medical College of Virginia Medical Alumni Association
6 pm: Cocktails — *Virginia Room*
7 pm: Banquet — *Virginia Room*

Non-Alumni Medical Alumni
6:30 pm: Cocktails — *Rooms D, E and F*
7:30 pm: Banquet — *Rooms D, E and F*

(Continued next page.)

(Specialty and alumni meetings cont'd.)

Saturday, November 6

Virginia Society of **Internal Medicine**
7:30 am: Breakfast — *Room E*

Christian Medical Society
7:30 am: Prayer Breakfast — *Room B*

Virginia Academy of **Family Physicians**
1 pm: Luncheon — *Virginia Room*

Virginia **Urological** Society
1 pm: Luncheon — *Room E*

Virginia Chapter, American Academy of **Pediatrics**
1 pm: Luncheon — *Room F*

Virginia Society of **Plastic & Reconstructive Surgery**
1 pm: Luncheon — *Room B*

Virginia **Dermatological** Society
6:30 pm: Cocktails — *Rooms D, E and F*
7 pm: Banquet

Sunday, November 7

Virginia **Dermatological** Society
12:30 pm: Luncheon — *Tidewater Room*

Host: The Portsmouth Medical Society

Arthur A. Kirk, MD,
Chairman of Arrangements

J. S. Garrison, III, MD	Vice-Chairman
John W. Hollowell MD	Hotels/Halls
Harry D. Cox, MD	Entertainment
Gerald Weitzman, MD	Scientific Exhibits
C. M. G. Buttery, MD	Press/Publicity
Harvey J. Breit, MD	Golf
Thomas H. Webb, MD	
Ronald L. King, MD	Tennis
Edward B. Ostroff, MD	
Fay I. Carr, Jr., MD	
James Vincent Scutero, MD	Bridge
A. A. Ruiz, MD	Hobbies
Emil S. Sayegh, MD	Sightseeing
Mrs. Gerald Weitzman	The Auxiliary

Scientific Exhibits

Exhibits prepared by members of The Medical Society of Virginia and allied professionals are placed in the *Exhibit Hall, North Ballroom, lower level,* and *in an area on the mezzanine adjacent to the auditorium.* Here are their topics and their sponsors.

Cardiac Rehabilitation. George W. Vetrovec, MD, *Richmond.*

Clinical Biofeedback. Michael L. Connell, MD, *Forest.*

Echocardiography in the Adult. Andrea Hastillo, MD, and Alice Goodman, BS, *Richmond.*

Gray-Scale Sonography of the Gall Bladder. Ira D. Green, MD; Walter Choi, MD; Michael Friedman, MD; William V. Hindle, MD; Allan Zellis, MD, *Alexandria.*

History of Surgery in Stamps. Ranes C. Chakravorty, MD, *Salem.*

Homebound Patient Care. H. S. Wise, MD, *Norfolk.*

Introducing and Reinforcing Infant Stimulation in Pediatric Practice. Joseph R. Zanga, MD, and Elizabeth G. Serow, MA, *Charlottesville.*

Knee Arthrography. Felix A. Hughes III, MD, *Virginia Beach.*

Management of Emergencies in Thoracic Surgery. Sibu P. Saha, MD, *Salem.*

Medical Evaluation Criteria under the Social Security Program. M. Jane Page, MD, *Richmond.*

Noninvasive Peripheral Vascular Assessment. Joel A. Schneider, MD; Harry A. Wellons, Jr., MD; Ivan K. Crosby, MD, *Charlottesville.*

Pediatric Dysmorphology. Meinhard Robinow, MD, *Charlottesville.*

Puzzles in Radiography. A. W. Hargroves, Jr., MD; Thomas E. Padgett, MD; Fay I. Carr, Jr., MD; J. S. Garrison III, MD; Ronald L. King, MD, *Portsmouth.*

Regionalization of Neonatal Care. G. W. DeWitt, MD, *Charlottesville.*

Two Hundred Years of Progress in Public Health. John R. Tietjen, MD, *Petersburg.*

The Virginia Medical Examiner System and the Department of Legal Medicine. M. F. Fierro, MD, *Richmond.*

Technical Exhibits

Here are the firms who have purchased exhibit space at the 1976 Annual Meeting. They are loyal friends, contributing significantly to the financing of the meeting and creating for Virginia physicians a practical area of uptodate information. Reward them, and yourself, by visiting these exhibits.

You will find these exhibits in the *North Ballroom, lower level.* The ballroom will be open from 12 to 5 o'clock on Thursday; from 9 to 5 on Friday; and from 9 to 1 on Saturday.

Armour Pharmaceutical Company, *Phoenix, Arizona.*

Beecham Laboratories, *Bristol, Tennessee.*

Biomedical Laboratories, *Burlington, North Carolina.*

Blue Shield of Virginia, *Richmond, Virginia.*

Boehringer Ingelheim Ltd., *Elmsford, New York.*

Bristol Laboratories, *Syracuse, New York.*

Ciba Pharmaceutical, *Atlanta, Georgia.*

Alan G. Day Distributors, *Baltimore, Maryland.*

David A. Dyer & Associates, *Roanoke, Virginia.*

Fisons Corporation, *Bedford, Massachusetts.*

C. B. Fleet Company, Inc., *Lynchburg, Virginia.*

General Medical Tidewater, *Newport News, Virginia.*

E. F. Hutton & Company, Inc., *Norfolk, Virginia.*

Eli Lilly and Company, *Indianapolis, Indiana.*

Mead Johnson Laboratories, *Evansville, Indiana.*

Medical Services of America, Inc., *Roanoke, Virginia.*

A. H. Robins Company, *Richmond, Virginia.*

Roche Laboratories, *Nutley, New Jersey.*

Sandoz Pharmaceuticals, *East Hanover, New Jersey.*

W. B. Saunders Company, *Philadelphia, Pennsylvania.*

Searle Laboratories, *Chicago, Illinois.*

St. Paul Fire and Marine Insurance Company, *St. Paul, Minnesota.*

Suter Associates Retirement Planning Company, *Arlington, Virginia.*

The Travelers Medicare, *Richmond, Virginia.*

Tidewater Psychiatric Institute, *Virginia Beach, Virginia.*

Wyeth Laboratories, *Philadelphia, Pennsylvania.*

The House of Delegates

Where no name is listed it is indicative that no delegate or alternate was reported in time for publication. Congressional district is given following name of component society.

Delegates	Alternates
Accomack (1st)	
D. F. Fletcher, Jr., MD	**E. W. Bosworth, II, MD**
Albemarle (7th)	
T. H. Bain, MD	**F. A. Berry, MD**
J. A. Owen, Jr., MD	**R. S. Brown, MD**
H. D. Smallwood, MD	**J. S. Davis, IV, MD**
O. A. Thorup, MD	**A. L. Huber, MD**
Munsey S. Wheby, MD	**R. A. Reid, MD**
Morton C. Wilhelm, MD	**W. M. Wallenborn, MD**
Alexandria (8th)	
R. H. Anderson, MD	**J. G. Brown, MD**
H. H. Ferrell, Jr., MD	**M. H. Kendrick, MD**
J. E. Gibson, MD	**J. P. McDade, MD**
I. J. Green, MD	**G. F. Miller, MD**
C. R. Meloni, MD	**J. W. Preuss, MD**
C. J. Murphy, Jr., MD	**R. J. Redding, MD**
H. G. Thompson, MD	**R. H. Ryan, MD**
Alleghany-Bath (6th)	
Amherst-Nelson (6th)	
Arlington (10th)	
J. C. Bucur, MD	**L. B. Burk, Jr., MD**
G. J. Fisher, MD	**W. D. Dolan, MD**
Robert H. Gruver, MD	**T. G. McWilliams, MD**
T. L. Kelly, Jr., MD	**S. J. Sheehy, MD**
R. P. Nirschl, MD	**B. C. Snyder, MD**
Augusta (6th)	
Bedford (6th)	
T. H. Jennings, MD	**J. R. Wenger, Jr., MD**
Botetourt (6th)	
Buchanan-Dickenson (9th)	
B. D. Berry, MD	**R. W. Hess, MD**
J. P. Sutherland, MD	**T. D. McDonald, MD**
Charlotte (5th)	
Chesapeake (4th)	
Culpeper (7th)	
G. E. Broman, MD	**N. C. Datta, MD**
J. R. Poole, MD	**D. F. Weaver, MD**

Delegates	Alternates
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E. J. Harvie, MD	L. G. Fehrenbaker, MD
J. W. Milam, MD	G. B. Updike, Jr., MD
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W. C. Bernhart, MD	R. J. Bortnick, MD
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E. O. S. Stevenson, MD	U. A. Shibaro, MD
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Floyd (5th)	
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Franklin (5th)	
Fredericksburg (7th)	
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W. R. Watkins, MD	F. G. Wray, MD
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H. E. Howell, MD	
Hanover (7th)	
Patrick Henry (5th)	
Henry Campbell, MD	R. E. Herring, Jr., MD
J. D. French, MD	B. C. Toms, Jr., MD
James River (5th)	
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Lee (9th)	
B. H. Owens, MD	
Loudoun (10th)	
Louisa (7th)	
Lynchburg (6th)	
Mid-Tidewater (1st)	
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Newport News (1st)	
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D. B. Young, MD	J. D. Via, MD
M. M. Miller, MD	S. R. Williamson, MD
Northampton (1st)	
W. S. Burton, MD	J. R. Mapp, MD
Northern Neck (1st)	
J. K. Cunningham, MD	J. S. Bacon, MD
A. B. Gravatt, Jr., MD	E. D. Brand, MD
H. E. Kerr, MD	R. L. Gilliam, MD
J. R. Lacey, MD	
Northern Virginia (7th)	
Orange (7th)	
W. S. Grabeel, MD	J. G. Bruce, Jr., MD
Portsmouth (4th)	
Prince William (8th)	
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C. J. Gueriera, MD	A. T. Ventzek, MD
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(Continued page 662.)

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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

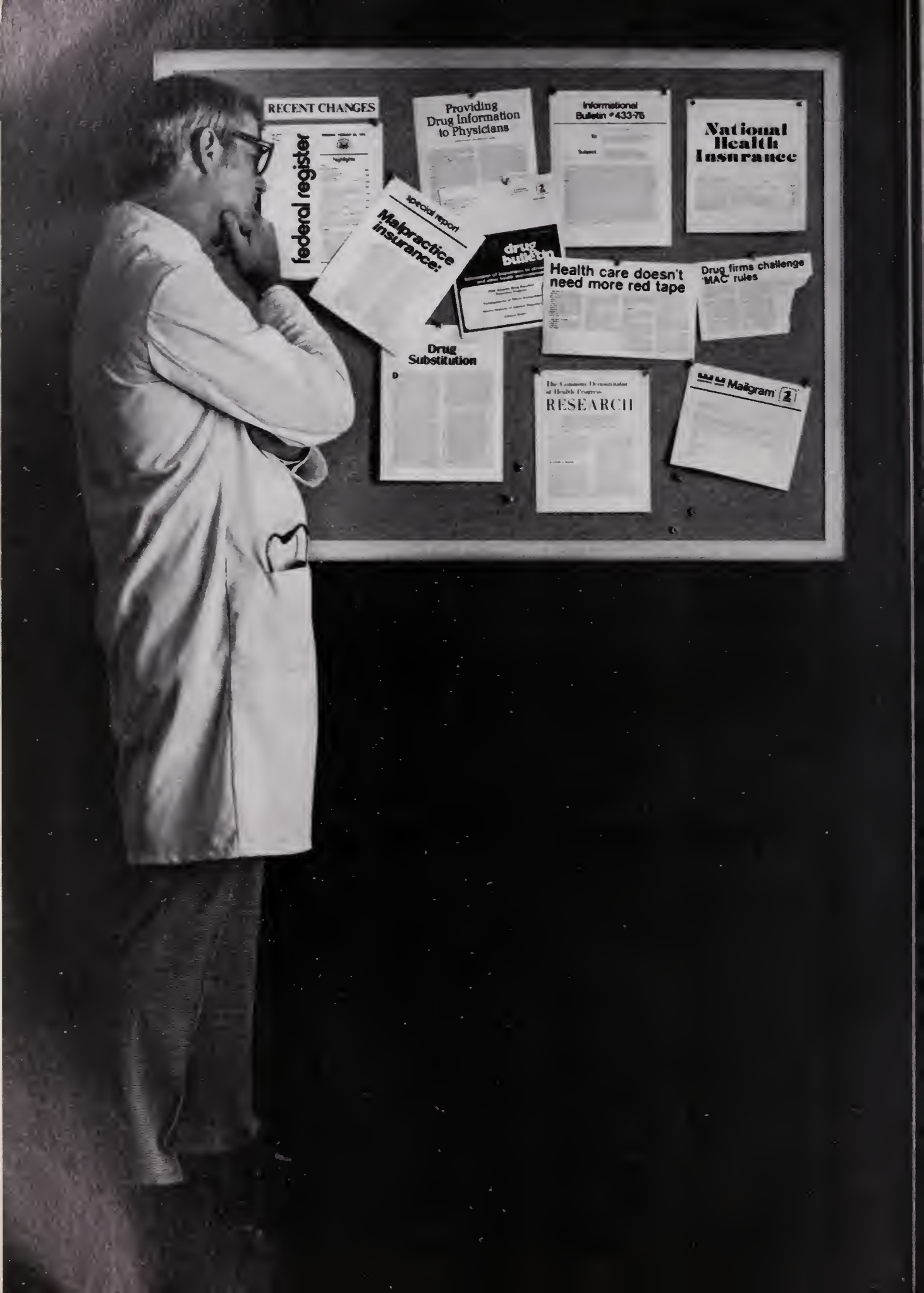
Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
A division of Pfizer Pharmaceuticals
New York, New York 10017


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-75
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all nds of scrutiny. Your control over patient therapy is ing monitored, judged and occasionally abrogated, metimes by unknown third parties.

The worry is that in the wake of this focus, the rela- onship between you and your patient will be weakened, ithout offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, gulations or professional custom stipulate that your n-generic prescriptions be filled with the precise prod- cts you prescribe. But in the last five years, a dozen or ore State laws have been changed, permitting the phar- acist in most cases to select a product of the same eneric drug to fill any prescription.

Ironically, this dilution of physician control has ken place against a background of growing evidence at purportedly equivalent drug products may be in- quivalent, since neither present drug standards nor their nforcement are optimal. In fact, the FDA itself says it as not enforced the same standards for hundreds of follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient herapy is being eroded with a risk that patients may be xposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

P·M·A

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

Delegates	Alternates
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W. R. Irby, MD	J. C. Jamison, MD
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E. L. Kendig, Jr., MD	R. G. McAllister, MD
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J. L. Ware, MD	E. R. Trice, MD
J. R. Wickham, MD	H. J. Warthen, Jr., MD
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E. A. Zakaib, MD	
Roanoke (6th)	
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T. E. Donnelly, MD	K. D. Tuck, MD
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R. D. Knopf, MD	J. W. Wilks, MD
E. L. Williams, II, MD	
Rockbridge (6th)	
Rockingham (7th)	
J. T. Glick, Jr., MD	
J. T. Hearn, MD	
Scott (9th)	
G. C. Honeycutt, Jr., MD	B. R. Adkins, MD
Southside Virginia (4th)	
Southwestern Virginia (9th)	
L. E. Dunman, MD	W. S. Barton, MD
J. H. Early, Jr., MD	F. S. Blanton, Jr., MD
R. V. Gailliot, MD	D. C. Blose, MD
G. Q. Gilmer, MD	D. M. Brillhart, MD
J. L. Givens, MD	C. S. Calilung, MD
J. T. Hulvey, MD	T. P. Davis, MD
G. B. Kegley, MD	W. C. Elliott, MD
C. D. Moore, Jr., MD	P. W. Fant, MD
J. L. Patterson, Jr., MD	J. W. Giesen, MD
Morgan E. Scott, MD	C. C. Hatfield, MD
G. R. Smith, Jr., MD	L. P. Hyde, MD
W. B. Waddell, MD	M. G. Martin, MD
	J. B. Stone, III, MD

Delegates	Alternates
Stuart (5th)	
Tazewell (9th)	
R. A. Abernathy, MD	J. M. Peery, MD
Tri-County (4th)	
Virginia Beach (2nd)	
F. K. McCune, MD	F. G. Griffin, MD
R. T. Mosby, Jr., MD	J. J. Krueger, MD
T. J. Wakeman, MD	J. H. Trant, III, MD
Williamsburg-James City (1st)	
J. S. Fletcher, MD	R. D. Cilley, MD
J. B. Hess, MD	W. J. Massey, III, MD
Wise (9th)	
MCV Student Medical Society (3rd)	

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The Auxiliary

Thursday, November 4

3 pm
Board Meeting — Room A

Friday, November 5

8 am
Breakfast — Rooms A and B

9 am
53rd Annual Meeting — Rooms A and B
Invocation, **Mrs. Maynard E. Emlaw,** *Richmond,* Chaplain
Mrs. Harold L. Williams, *Newport News,* President, Presiding Officer.
Address of Welcome, **Mrs. Joseph J. Allen,** *Portsmouth,* President, the Portsmouth Auxiliary.
Response, **Mrs. John Hannon,** *Falls Church,* 3rd Vice-President.
Presentation of Guests, **Mrs. Williams.**
Announcements, **Mrs. Gerald Weitzman,** *Portsmouth,* Convention Chairman
Roll Call, **Mrs. Donald M. Callahan,** *Harrisonburg,* Recording Secretary

Committee Reports
Credentials, **Mrs. Frank Denaro, Jr.,** *Portsmouth,* Chairman.
Reading, **Mrs. Donald E. Sly,** *Norfolk,* Chairman.
Auditing, **Mrs. Eugene O. S. Stevenson,** *Springfield,* Chairman.
Treasurer, **Mrs. L. C. Strong, Jr.,** *Norton.*
AMA Delegates, **Mrs. Strong,** Chairman.
Finance, **Mrs. Vedii Ayyildiz,** *Salem,* Chairman.

Recommendations from the Board, **Mrs. Callahan.**

Keynote Address, Mrs. William J. Reardon, *Fairfax,* Past President and national AMA-ERF Chairman, introduced by **Mrs. Richard F. Clark,** *Hampton,* Program Chairman.

President's Scrapbook Presentation, **Mrs. Alan C. Hampshire,** *Newport News,* Historian.
Nominating Committee Report, **Mrs. Randolph H. Hoge,** *Richmond,* Chairman, followed by Election of Officers.
Courtesy Resolutions, **Mrs. Robert L. Wood,** *Richmond,* Chairman.
Recess.

12 noon
Annual Luncheon — Virginia Room
Mrs. Williams, Presiding Officer.
Invocation, **Mrs. Emlaw.**
Bicentennial Tribute, **Marilyn Dozoretz** and **Regina Katz,** pianists.
Presentation of Awards, **Mrs. Charles S. Sale,** *Norfolk.*
Installation of Officers, **Mrs. Daniel N. Anderson,** *Norfolk,* Past President.
Presentation of President's Pin, **Mrs. Williams.**
Acceptance, **Mrs. William N. Gordge,** *Roanoke,* President-Elect.
Announcements, **Mrs. Fay I. Carr, Jr.,** *Portsmouth,* Convention Cochairman.
Adjourn.

Saturday, November 6

8 am
Past Presidents Breakfast — *Room D*

8:15 am
Breakfast for Board Members — *Room A*

9 am
Board Meeting — *Room C*
Mrs. Gordge, Presiding Officer.

9 am
Singles **Tennis** Tournament for Women.

9:30 am
Women's **Golf** Tournament.

1 pm
Williamsburg **Flower Arranging Demonstration** — *Room C*

Hostess: The Auxiliary to the Portsmouth Medical Society

Mrs. Gerald Weitzman, Chairman
Mrs. Fay I. Carr, Jr., Cochairman

Mrs. Frank Denaro, Jr. ..... Secretary-Treasurer
Mrs. Thomas Padgett ..... Luncheon
Mrs. Edward Barham
Mrs. H. Dale Sponaugle ..... Hospitality
Mrs. Kenneth L. Mayes
Mrs. Ralph M. Stokes ..... Tickets/Artwork
Mrs. David A. Rosin ..... Flowers/Courtesies
Mrs. Richard T. Deaton
Mrs. Ben L. Critzer ..... Pages/AMA-ERF
Mrs. Ronald L. King ..... Tennis
Mrs. Harry D. Cox ..... Golf
Mrs. Lemuel Mayo
Mrs. Juan M. Montero, II ..... Publicity
Mrs. Thomas H. Webb ..... Special Events

The Medical Society of Virginia
PROCEEDINGS

Annual Report of the Executive Vice-President

HOW OFTEN HAS IT BEEN SAID that "there is nothing new under the sun"? Well, we can now state with some authority that another "profound" saying has been found to be just another myth. At least this is the case where medicine is concerned.

Just when we thought there was no way that the "planners" residing on the North banks of the Potomac could surprise us further, along they come with new legislation, new proposals and new regulations—all conceived for the purpose of proving how wrong we can be! We are specifically referring to PL93-641 (HSAs), S 3239 (Health Manpower) and the new Utilization Review Regulations (proposed as this report goes to press).

PL93-641 has been called many things — including the forerunner of National Health Insurance. Physicians have viewed the establishment of HSAs with concern — and rightly so.

If the planners would agree to stop coming up with their unbelievable surprises, we would gladly admit that they win all the awards for imaginative programs and proposals in the categories of "shock" and "disbelief". We are afraid, however, that their success to date has so whetted their appetite that they will never cease and desist voluntarily.

Should there be any who still believe that medicine is not the number one target of the bureaucrats, they need only reflect upon the changes which have taken place during the last 40 years or so. Remember when the "New Deal" was uppermost in everyone's minds — and the nation was concerned with such things as NRA, WPA, PWA, CCC, etc. Now the alphabet game is played with such stock designations as HSA, PSRO, HMO, NHI, NIH, HEW — and on and on. In other words, health care in general and medicine in particular are the "key" areas of activity in the never-ending political struggle of our Nation. The question before us is not whether the delivery of health services can be improved—but whether medicine as we have known it can survive the attack of the federal bureaucracy.

Before all of us become so pessimistic that we simply throw in the towels of frustration and despair, let us take heart in the glimmer of hope that still remains. This hope can be found in the determination of the American Medical Association to contest bad legislation and regulations whenever and wherever they make their appearance. It has earned a new respect among physicians—and all Americans—for its willingness to take up the spear against the Federal dragon.

And that brings us to one of the pressing issues facing Virginia physicians at this time—the issue of AMA membership. For some reason, Virginia has never been counted among those states with a representative number of AMA members. It will serve no good purpose to speculate on the causes at this late hour. Suffice to say that AMA has proved its right to represent and speak out for the American physician, and the time has come for all members of The Medical Society of Virginia to support their national association through membership.

This Bicentennial year is something special for Americans, and something extra special for Virginians. How appropriate it is that a Virginian—Dr. Richard E. Palmer—is President of the AMA at this particular time. Those fortunate enough to hear his inaugural address at Dallas were stirred as they have not been for many years, and will tell you that fires long dormant were rekindled by his positive assessment of the situation and his avowed determination

o wage an aggressive battle on behalf of American nedicine. June 30 was indeed a great day for Virginia—made doubly so by the participation of the horus of the Roanoke Academy of Medicine Auxliary. What wonderful emissaries these lovely ladies vere for our state!

There are obviously a great number of subjects we vould like to discuss with the membership, but this eport must necessarily deal with facts and figures ıssociated with the Society's operation during the ast twelve months. With that thought in mind, we vill proceed to bring you up to date on those matters which tell the story from the administrative point of view.

PRESIDENT AND COUNCIL:

When Dr. Raymond Brown was installed as President last October in Roanoke, the membership knew that it once again was blessed with the caliber of leadership which has become a tradition with The Medical Society of Virginia. What the membership did not know was just how blessed it really was. Under Dr. Brown's leadership, the Society accomplished what many said could not be done—the enactment of a legislative program designed to cope with the malpractice problem. Although the entire "package" was not enacted, the legislation represented a giant first step in the right direction. The sincere yet firm manner in which Dr. Brown presented the Society's case was one of the main reasons for this achievement. We did not keep count of the number of times he made the trip from Gloucester to Richmond, but there were not many days from January to March that he was not on the road. And there have not been many weeks since then when he has not been either at Society headquarters or somewhere else working in behalf of the physicians of Virginia.

Those of us who have had the privilege of working with this warm and gentle man will miss the feeling of strength and sense of purpose he instilled in us all. He has renewed our faith in the future, and provided the inspiration to redouble our efforts on behalf of the greatest medical care system the world has ever known.

Council will have met on four occasions by the time the Annual Meeting rolls around. We doubt that the average member is really aware of the tremendous job being carried on by his Councilor. Each and every one of them deserve our most sincere gratitude.

MEMBERSHIP:

If growth is a sign of health, then your Society is in remarkable good condition. While a steadily increasing membership in indicative of many things, we are most enthusiastic over the fact that it brings more physicians under the same banner. Unity is more important today than ever before. In fact, it could well be the key to survival. The complete membership story follows in detail:

August 1, 1975			5,165
New Members	599		
Reinstated	28		
		627	
Deaths	47		
Resigned	54		
Dropped	157		
		258	
Net Increase			369
July 31, 1976			5,534

VIRGINIA MEDICAL MONTHLY:

It is not easy to follow the feature act—any performer will testify to that fact. That was the position in which Dr. W. T. Thompson, Jr. and Mrs. Gray found themselves when they took over as Editor and Managing Editor of *Virginia Medical Monthly*. For many years, Dr. Harry J. Warthen and Miss Watkins had turned out one of the best Society publications in the nation. But Dr. Thompson and Mrs. Gray have met the challenge in magnificent fashion, and the "Monthly" continues to get better with each issue.

FINANCES:

We have both good and bad news with reference to the Society's financial situation. The good news is that we are still financially sound—perhaps more so than any state society in the nation. The bad news is that increasing demands—many of them undreamed of twelve months ago—are being made on the Society treasury, and sooner or later something is going to have to give. We give you our promise, however, that no funds have been, or will be, spent frivolously or without proper authorization and justification. Whether an increase in dues will be found necessary by the House this November will depend upon the findings and recommendations of the Finance Committee at the end of the fiscal year. Bear in mind that the last dues increase was authorized in 1973. We will do our best to extend that record.

PERSONNEL:

For many years, The Medical Society of Virginia had little turnover among its personnel. But time

marches on and the villain known as "retirement" finally caught up with us. Mrs. Edmunds has joined Miss Watkins in the "good life," and her experience and overall efficiency are sorely missed. Mrs. Jones has also found it necessary to resign and will leave us all too soon.

This means that a thorough reorganization of the staff and its responsibilities is vital if the job is to be done as you would have it. No longer can we afford the luxury of a staff sufficiently flexible to "double in brass". Membership records, continuing medical education, *Virginia Medical Monthly*, bookkeeping—all are full-time pursuits. Our legislative activities keep Mr. Osburn busy most of the year. All of which means that a great deal of the routine administration often falls behind, and services to individual members sometimes feel the pinch.

In order to do the job properly, we have established five basic areas of responsibility: 1) Membership Services; 2) General Administration; 3) Legislative Activities and Special Functions; 4) Virginia Medical Monthly—including advertising and exhibits; and 5) Continuing Medical Education. In addition to these five areas, the Executive Vice-President will continue to be directly concerned with the House of Delegates, Council, Executive Committee, budgetary matters, annual meeting, Long Range Planning, legal matters, implementation of policy, etc. We have high hopes that these changes and adjustments will result in the excellence of performance we are constantly striving to achieve.

HEADQUARTERS BUILDING:

Several years ago the House of Delegates directed that a special building fund be established for the purpose of financing the long overdue expansion of our present facilities. For some time we have been without an inch of extra space, and all of our larger meetings have been moved to hotels and other locations. Since receiving that directive, we have deposited $75,000 in the special fund, and the time appears to have arrived when needed expansion should be commenced. We hope to soon have facilities second to none, and will keep you informed as to our progress.

MEETINGS:

The number of meetings attended by Society representatives seems to increase a bit each year. Although the President does his best to attend as many as possible, it has become necessary for other officers to share part of the load. Just take a quick glance at some of the meetings attended by at least one official Society representative: AMA House of Delegates (two sessions), AMA National Leadership Conference, Virginia Council on Health and Medical Care, State Board of Medicine (two sessions), National Rural Health Conference, Conferences of State Society Presidents, State 4-H Club Health Awards Ceremony at Blacksburg, Virginia Professional Standards Review Foundation, AMPAC Workshop, annual meetings of five neighboring state medical societies—and many more.

LOOKING HEAD:

The only thing that is truly predictable about the future these days is it unpredictability. Since this is a presidential year, there is no way of knowing just what the Federal establishment has in mind for us—other than that it will not be good. That we can safely predict! The presidential candidates are uttering the usual campaign rhetoric about health, although at least one has left no doubt as to where he stands on national health insurance. He has made it clear that he intends, if elected, to see that a program of some type is enacted at the earliest possible moment.

As we look back on the past twenty years and then try to look ahead, we cannot help but realize that the time for compromise is over. It could well be that medicine has already compromised itself into a corner from which there is no escape. But, this is 1976—our nation's 200th birthday—and the spirit of '76 is with us once again. This, then is certainly the time to stand up for America and American Medicine. As Dr. Palmer stated it so well in his inaugural address, this is a time for all of us "to strive, to seek, to find, and not to yield, to walk tall against the night, and to see, beyond the night, the morning star . . ."

Robert I. Howard
Executive Vice-President

Annual Reports of Committees, 1976

Advisors to Virginia AAMA

DURING 1975-76, the Advisors have tried to promote the growth of this association, have been available to counsel when called upon and also have been available at the Executive Board meetings during the year. Letters have been sent out through The Medical Society of Virginia promoting the annual educational seminar and also the annual convention of the Virginia Society of AAMA.

Dr. Earley attended the 1975 National Convention and escorted the President, Myrt Ingvaldsen, in the Parade of Presidents. He also attended an organizational meeting in Williamsburg after the state convention last year.

Dr. Hagan attended an organizational meeting for the Potomac Chapter. He also wrote a letter to the physicians and medical assistants in Halifax County and participated in an organizational meeting for the new Southside Chapter at this site. Although an advisor did not attend the organizational meeting of the new Loudoun County Chapter, we stand ready to assist this chapter if called upon.

We feel that the Virginia Society of AAMA has had another year of accomplishments, and it has been a pleasure for us to participate in the growth of this organization.

Ralph E. Hagan, MD, Chairman
Charles M. Earley, MD
Lawrence D. Young, MD
David B. Young, MD
Robert I. Howard

AMA Delegates

ONCE AGAIN your Society was well represented at both the Annual and Clinical Sessions of the American Medical Association, the former in Dallas and the latter in Hawaii. Your delegates can report that AMA is indeed alive and well and has never been more active in your behalf. Since the many actions of the House of Delegates have already been reported in the *JAMA* and *American Medical News*, it would serve no useful purpose to repeat them here. We would remind you, however, that information on any specific action can be obtained by contacting Society Headquarters.

This has been a big year for Virginia. Dr. Richard E. Palmer was installed as AMA President during the meeting in Dallas—the third Virginian so honored. The inauguration ceremony was featured by the appearance of the Roanoke Academy of Medicine Chorus, a talented and versatile group which has become quite well known in the southeast. We must say—even at the risk of being called prejudiced—that the ceremony was the best and most exciting in our memory.

Your delegates can not help but wonder why Virginia has not done better where AMA membership is concerned. In the last seven years, membership in The Medical Society of Virginia has increased by approximately 2,000. During this same period, the number of AMA memberships in Virginia has increased by only about 600! This is the reason why the question of unified membership is before the Society.

AMA remains medicine's first and strongest line of defense—the only really effective deterrent to those who advocate the complete socialization of medicine. AMA might not be perfect—but it is by far the best of its kind anywhere in the world! It deserves the full support of every physician in this great nation. Virginians have always been looked to for leadership, no matter what the occasion. Why, then, can't we also be leaders where AMA membership is concerned.

We only wish it were possible for every Virginia physician to attend with us a meeting of the AMA House of Delegates. It is a refreshing, eye-opening experience, particularly for those who ask, "What does AMA do for me?" The truth of the matter is—dollar for dollar, your AMA dues represent your biggest and best bargain on today's market. How can you put a price on freedom!

William S. Hotchkiss, MD
Michael A. Puzak, MD
F. Ashton Carmines, MD

Child Health

THE COMMITTEE ON CHILD HEALTH held one meeting during the past year and submits the following report of its actions.

Dr. Chalkley reviewed the report of Reference Committee #2 in conjunction with last year's Annual Meeting. The report recommended that the following subjects be referred back to the Committee for clarification: preschool health examinations, immuniza-

tions, newborn insurance, nurse practitioners and programs for gifted children.

Preschool Examination: The previous report was submitted as a matter of information and no action was necessary by the Society. The preschool health form has been widely used and well accepted by the medical profession, and carries the approval of the Committee. However, it was suggested that when the State Health Department contemplates a revision, the form be presented to the Committee for its suggestions and recommendations since the Committee represents a cross-section of pediatricians over the state.

Immunizations. This section of the report was submitted as a matter of information, and required no action. It was pointed out that the mumps vaccine is still being supplied to some local health departments in small quantities, and the Committee expressed the hope that a more ample supply could be made available.

Newborn Insurance. The Committee learned that through the cumulative efforts of many physicians, HB-128 regarding coverage of newborn children is now a matter of record. The section over which the Committee expressed its concern in the previous report is now incorporated in the law. The section reads as follows: *The requirements of this section shall apply to all insurance policies and subscriber contracts delivered and issued for delivery, reissued or extended in this state on and after November 1, 1976. An insurance policy written before November 1, 1976 shall be deemed to be reissued or renewed if the provision of that policy or contract allow the insurer to change the terms of the policy or contract or adjust the premiums charged, and if a change or adjustment is made on or after November 1, 1976.*

Nurse Practitioners. The Committee discussed the nurse practitioners and pediatric nurse practitioners, and it was the consensus that the programs are excellent and have the approval of the Committee. However, the Committee did express its opinion that these practitioners should be under the direct supervision of a physician.

Gifted Children. The previous report on gifted children was submitted as a source of information with no action required. The Committee had previously suggested that equal monies be spent on both the gifted child as well as the impaired.

Child Abuse. A progress report on child abuse was presented by Dr. Hunt, as prepared by the Chief of the Bureau of Child Protective Services, Department of Welfare. The Committee learned that of the 6,023 instances of alleged abuse or neglect surveyed, 69% (4,200) proved to be valid complaints. The information was based on evidence as evaluated by the local welfare worker assigned this responsibility. It was pointed out that children with developmental difficulties are at a greater risk of being abused or neglected. The children who are abused have a greater risk of developing physical, mental, and emotional problems.

It was noted that the reporting of child abuse is much greater since the individual is no longer required to identify himself. The reports are not made to officers of a court but to special service professionals. The Committee learned a central hotline is now operational on a 24-hour, 7-day-a-week basis, and anyone may call to report suspected child abuse and neglect through a toll-free statewide number (1-800-552-7096). Should individuals not wish to use the hotline they can contact their local county or city welfare department.

The Committee was very concerned over the high number of complaints, and questioned what constituted a valid complaint. It is hoped that additional information can be obtained from the State Health Department regarding these statistics.

Swine Flu. The Committee discussed the swine flu problem and learned that the State Health Department is developing a plan for immunization. It was pointed out that the American Academy of Pediatrics will have a position on swine flu in the near future, and the Committee will support the action recommended by this organization regarding vaccinations in the state.

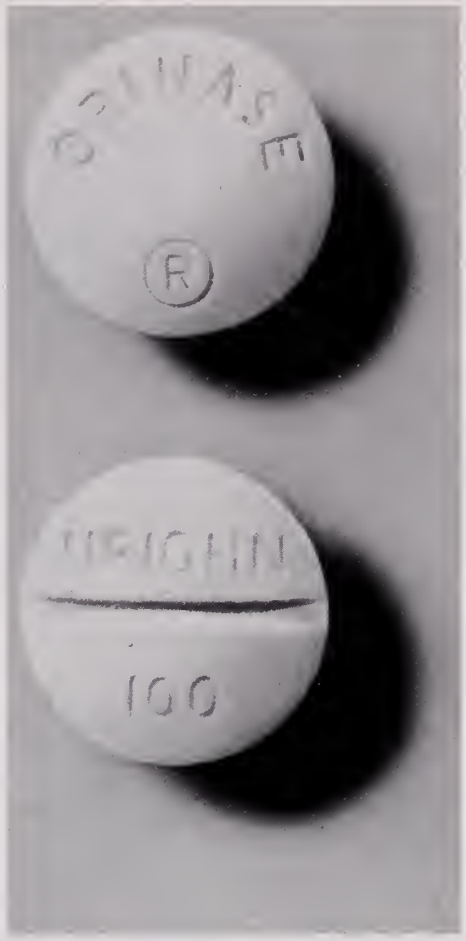
Immunization Action. Dr. Chalkley pointed out that he represented the Committee as a member of the Immunization Action Committee on a state level. He indicated that the Committee did an excellent job in reporting immunizations, and the final report revealed that the children in Virginia are high above the average in receiving immunizations compared with the rest of the nation.

EPSDT. Dr. Chalkley called attention to the fact the American Academy of Pediatrics had contacted the Committee concerning the status of EPSDT (Early Periodic Screening, Diagnosis and Treatment) in Virginia. Since no special committee on EPSDT exists, the Academy was advised to contact Dr. Patricia Hunt and Dr. William Grossman. It was pointed out that Dr. Grossman was very familiar with EPSDT activities.

Child Find Program. The Committee learned that Mr. Tom Chalkley, Jr., has been appointed Director of Project Child Find for Virginia. This program is designed to locate all children between birth and the age of 21 with special needs. The children would include those who have defects in sight, hearing, speech or learning disabilities. It would also include

(Continued on page 675.)

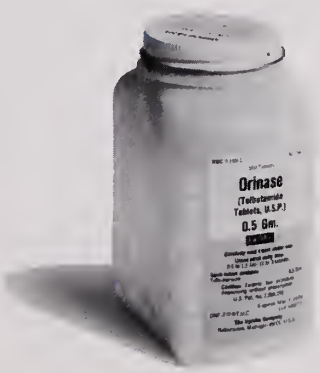
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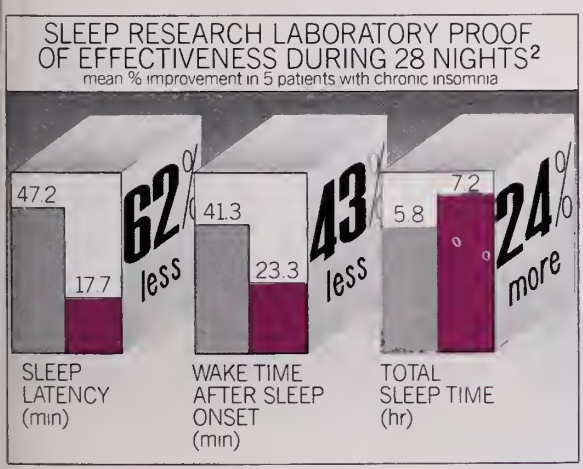

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For insomnia that is a chronic problem...

Only Dalmane (flurazepam HCl) offers sleep laboratory proof of effectiveness for as long as 28 nights

Continued relief of insomnia in patients with chronic insomnia

Since insomnia is often transient and intermittent, the prolonged administration of a hypnotic is generally not necessary or recommended. But when insomnia is a chronic or recurring problem, continued effectiveness is as important as initial effectiveness. Results of a recently published sleep research laboratory study[1] demonstrated that, while pentobarbital lost effectiveness within two weeks, Dalmane maintained effectiveness for 28 consecutive nights. Similar 28-night results with Dalmane, displayed below, were obtained by a second sleep research group.[2] In previous studies,[3] both chloral hydrate and glutethimide began to lose effectiveness after several nights, while Dalmane maintained effectiveness throughout the 14 medication nights. Whether the problem is difficulty falling asleep, staying asleep or sleeping long enough, consider these results when selecting a sleep medication.



Patient benefits include relative safety, infrequent morning "hang-over"

Dalmane is well tolerated, seldom causing morning drowsiness or grogginess.[4] No increase in dosage is required for continued effectiveness from night to night.[1-3] Should Dalmane be used repeatedly, periodic blood counts and liver and kidney function tests should be performed. The usual adult dose is 30 mg *h.s.*, but 15 mg may suffice for some patients and is recommended as a starting dose for the elderly and debilitated to help preclude oversedation, dizziness or ataxia.

Continued relief of insomnia: One more good reason to specify

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

whenever a hypnotic is needed

ROCHE

Please see following page for a summary of product information.

New objective proof: continued insomnia relief without increasing dosage...[1,2]

Dalmane®
(flurazepam HCl) ℞ IV

Objectively proved in the sleep research laboratory...

during 28 consecutive nights of administration:

- ☐ **effectiveness with a single 30-mg *h.s.* dose, maintained**
- ☐ **rapid sleep induction, maintained**
- ☐ **sleep for 7 to 8 hours, on average, maintained**
- ☐ **less time awake during the night, maintained**

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum benefic effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

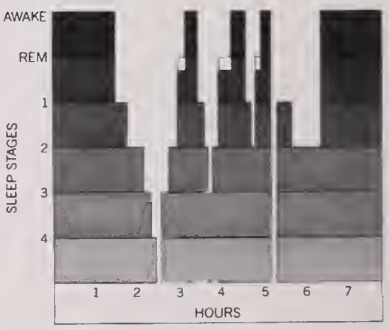
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



REFERENCES:

1. Kales A, *et al*: *Clin Pharmacol Ther* *18*:356-363, Sep 1975
2. Dement WC, *et al*: Long-term effectiveness of flurazepam 30 mg *h.s.* on chronic insomniacs. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, Jun 30-Jul 4, 1975
3. Kales A, *et al*: *Arch Gen Psychiatry* *23*:226-232, Sep 1970
4. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

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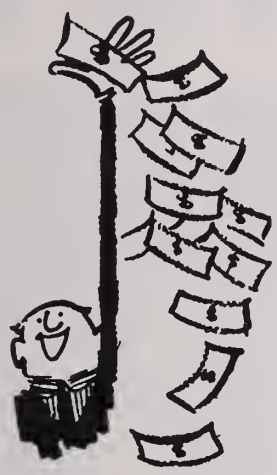
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(Continued from page 668.)

the mentally retarded, emotionally disturbed or physically handicapped. It was pointed out that the program not only seeks to locate these individuals, but also works with the public school system to plan appropriate educational and training programs.

Thomas S. Chalkley, MD, Chairman

Conservation of Sight

THIS COMMITTEE has become well aware of the growing trend in Virginia, as in other states of the nation, that threatens the conservation of sight for the citizens of the United States.

This threat is the established fact that organized optometry wishes to be the primary entry into eye care for the public, delegating ophthalmologists to a secondary position. Optometry also, by legislative means, is trying to obtain legal use of drugs, of the position of being able to diagnose and treat diseases of the eye; and the Committee recognizes that the public must be protected from inadequately trained practitioners.

The Committee has been working closely with the Virginia Society of Ophthalmology and Otolaryngology, hoping to better acquaint and inform their colleagues of the threat of this paramedical organization that will certainly undermine the care of the eye in the United States. It is felt that this should not be allowed to take place if the Committee on Conservation of Sight is to have any meaning.

The Committee invites any member of The Medical Society who wishes to express his feelings on the subject to do so in writing so that an answer can be formulated to better inform every person involved.

W. Conrad Stone, MD, Chairman

Ethics

WE SOMEHOW have the feeling that problems associated with medical ethics increase as frustrations increase within the medical community. As medicine is saddled with more and more legislative controls and bureaucratic regulations, one can almost predict the increase in the number of inquiries about ethics—stemming from the uncertainties of our time.

Most of the problems referred to the Committee during the year were fairly routine and, consequently, were handled without the necessity of holding a formal meeting. They covered such matters as drug repackaging, insurance forms, proper use of prescription pads, laboratory kickbacks, etc. As this report is readied for publication your Committee is preparing to meet in special session for the purpose of hearing an appeal of a component society action involving membership expulsion.

Since the Committee is receiving more and more inquiries about the ethics of charging for the completion of insurance forms, we believe it will be helpful to quote the following from the Opinions and Reports of the AMA Judicial Council: "The attending physician should complete without charge the appropriate 'simplified' Health Insurance Council forms approved by the Council on Medical Services, and similar insurance claim forms as a part of the physicians service to the patient to enable him to receive his benefits. A charge for more complex forms may be made in conformity with local custom. This suggestion is advisory. In all cases, the local medical society can be looked to for an authoritative opinion."

Your Committee recognizes the fact that while medical ethics are basic and fundamental, they are nevertheless subject to honest differences of opinion. We do believe, however, that all physicians appreciate the obvious importance of having a definite set of rules and guidelines by which all of us must live and practice. As the Judicial Council so aptly puts it, ". . . the principles of medical ethics are truly guidelines to good conduct."

Thomas M. Fulcher, MD, Chairman

Insurance

THE COMMITTEE held two meetings during the past year for the purpose of reviewing the Society's overall insurance programs. Among the items discussed were retirement, professional liability, coordination of benefits and Blue Cross-Blue Shield. Your Committee is pleased to report that all programs are in sound condition and doing exceptionally well.

The matter of professional liability insurance is always of particular interest to the membership, and the Committee wishes to call attention to the latest update from the St. Paul Companies.

The Committee learned that the basic mature rate will remain unchanged for the next year. The second year's premium, however, will increase approximately 25% (representing the second year of the claims-made approach). This is in keeping with St. Paul's plans announced last year and represents an orderly progression in the premium rate structure for the first four years of the claims-made plan. It was estimated that approximately 40.7% of the claims last year were "claims-made" related. It is predicted that approximately 65% of those reported in the next year will be "claims-made" related.

The Committee was advised that a new classification plan will soon be in effect, a result of a request by the National Association of Insurance Commissioners. It is hoped this will make it possible for physicians to be classified in a more realistic manner, thereby resulting in substantial premium savings for many of our members.

The Committee requested that St. Paul reopen a 30-day enrollment period for a disability waiver premium for the claims-made policy. The rider would pay for the physician reporting endorsement should his practice be terminated because of illness, etc. St. Paul approved the Committee's suggestion, and the membership has been contacted regarding the disability rider. Your Committee is fully cognizant of the responsibility it has in reviewing the insurance programs for the Society and would always welcome comments and or suggestions from the membership.

John W. Giesen, MD, Chairman

Health Careers

THE HEALTH CAREERS PROGRAM of the Virginia Council on Health and Medical care has continued its active program with the support of the Society's Health Careers Committee. The Committee's Chairman has provided consultation to the Council's program several times during the year, notably in revising the physician component of the Council's publications and reviewing movies for use in high schools.

The Council's program was presented to 49,903 students in 249 high schools during the year, resulting in 4,280 students requesting further details of a career in medicine.

Fred J. Spencer, MD, Chairman
William M. Massie, MD
William H. Sipe, MD
Belle D. Fears, MD
Roger Cornell, MD

Liaison to State Bar

THE JOINT MEDICO-LEGAL PLAN for Screening Malpractice Cases heard nine cases during the past 12 months, which was an increase of four cases over the previous year. Approximately 100 cases have been heard since the Panel was organized in 1961 by The Medical Society of Virginia and the Virginia State Bar. Due to legislation effective July 1, 1976, as enacted by the General Assembly, no additional cases will be heard by the Joint Screening Panel.

The Panel's function is expected to be performed by a Review Panel provided for under Chapter 611 of the Acts of 1976. This Act will make available to health care providers, and those claiming to have been injured by them, a medical malpractice review panel under the jurisdiction of the court, with a judge presiding, in the Congressional district where the alleged injury occurred. Plaintiff's attorneys inquiring about our plan are advised to obtain a copy of Chapter 611 from the Clerk of the House of Delegates.

The Committee would like to take this opportunity to express its appreciation to the Virginia State Bar for the excellent cooperation it has received over the past 15 years. As Chairman of the Committee, I would personally like to recognize the Panel members of both organizations. The members, through their dedicated efforts, made the Panel very successful in providing a service not only to physicians but to the public as well.

George M. Nipe, MD, Chairman

Long-Range Planning

YOUR COMMITTEE held a very interesting meeting at Society headquarters in July. Its agenda contained a number of important matters, most of which had been referred either by the House of Delegates or Council. It is for this reason that we are using excerpts from the minutes of that meeting as the basis of this annual report.

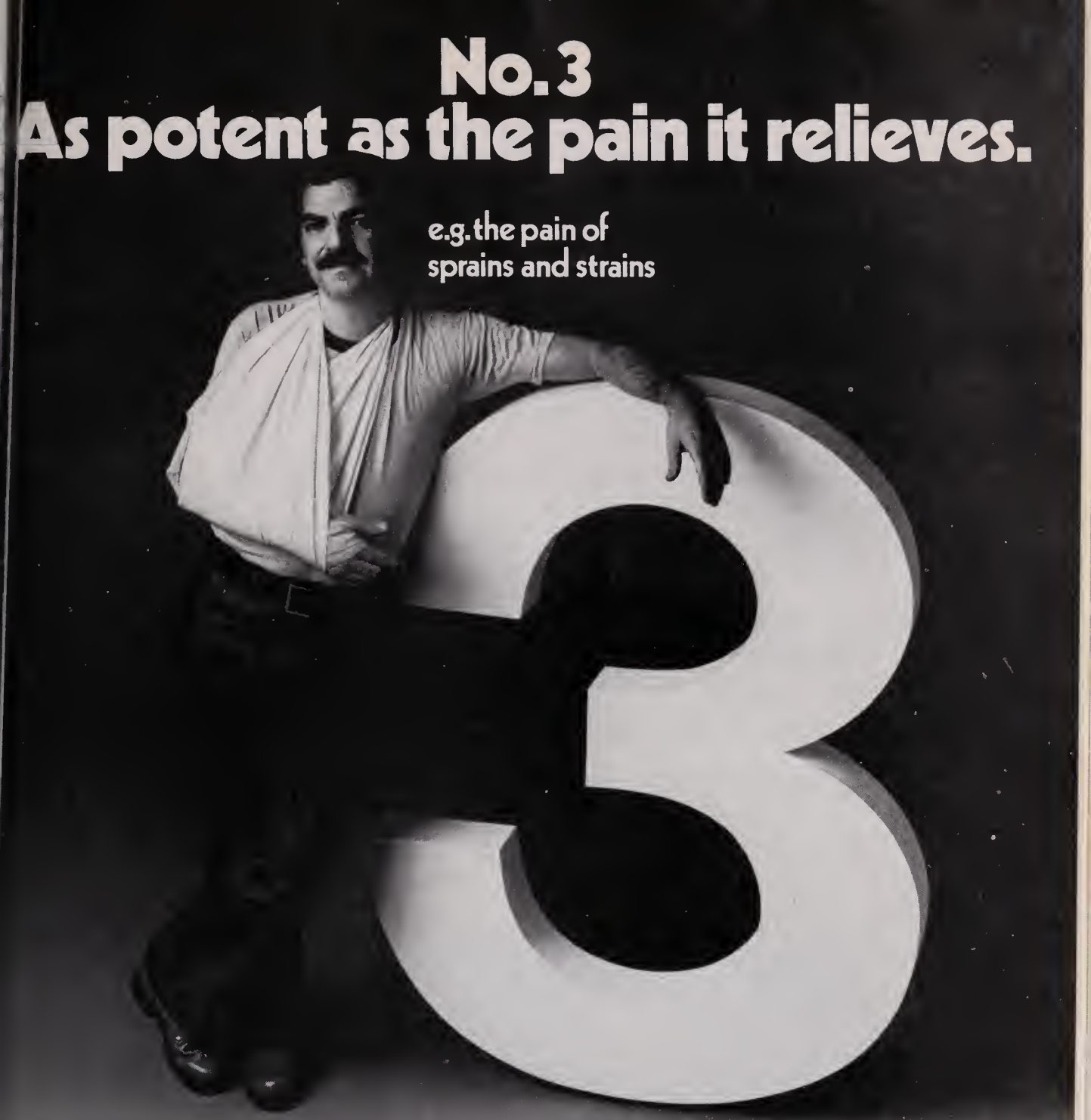
Conferences for Component Society Officers. The Committee was requested to consider the advisability of sponsoring periodic conferences for officers of component societies. Such conferences would be for the purpose of improving communications—a need which many believe has existed for some time. The cost involved would run somewhere between $600-$1,000.

It was the consensus that the President should feel free to call such a conference whenever he feels the need is indicated. The Committee recognized the importance of maintaining effective communications with component societies and agreed that a conference of this kind would represent a giant step in that direction. Brought out was the fact that although similar conferences had been presented in the 1950's, their need and importance would appear much greater today.

It was pointed out that the question of unified membership is so important that an officers' conference to consider this subject alone would be justified. Consequently, it was decided that such a conference would be arranged for Sunday, September 26, in

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Richmond. Dr. Brown indicated that a meeting of Council will be called on Saturday, September 25. This will enable the Councilors to stay over and participate in this very important conference.

Unified membership was discussed at some length, and all members of the Committee were in agreement as to its desirability.

Annual Meeting Extension. It has been suggested that the length of the Annual Meeting be extended by one day. The reasoning behind the suggestion is that numerous activities pose a difficult scheduling problem; consequently, it is not possible for those attending to participate in all the functions they would like.

Although it was agreed that the suggestion has some merit, there was considerable doubt that an extension would prove generally popular. The possibility of a second session of the House was discussed, but there was some question as to whether there would be a sufficient amount of business to justify the additional expense. It was also brought out that annual meetings have already been scheduled through 1983, and it might be difficult to schedule an extra day.

It was agreed that the Committee should report to Council that although it had discussed the matter in some detail, it had no definite recommendations at this time.

General Assembly Participation. The Committee was advised that it is becoming more and more important for members of the Society to testify before members of the General Assembly. Many are asked to come to Richmond on extremely short notice and often do so at great personal sacrifice. Because of this, a suggestion has been made that the Society seriously consider compensating these witnesses in some fashion.

It was agreed that most members are, for the most part, quite happy and willing to serve the Society without concern for compensation. It was also agreed that it should be most difficult to draw a set of acceptable guidelines for such compensation as travel expenses, honorariums, etc. Everyone believed that most members would rather leave the matter as is.

President's Income. Considerable discussion was devoted to the question of whether presidents of the Society should receive a stipulated income in addition to their present $3,000 expense account. It was pointed out that heavy demands upon the office leave the President no alternative but to curtail his practice. For many, this means a considerable loss of income.

The thought was expressed that the sacrifice involved automatically eliminates a great many physicians from consideration for the office. Those in solo practice are most affected. It was brought out, however, that there has been no shortage of candidates thus far and that the Society has always been blessed with capable presidents.

After considerable discussion, it was the concensus that special financial consideration for presidents should not be provided. It was agreed, however, that the Finance Committee should be requested to consider the inflation factor when recommending the President's expense account for the coming year.

Dr. Martin suggested that a luncheon for past presidents be held during the Annual Meeting, and a motion to this effect was seconded and carried. It was agreed that the luncheons should begin in 1977.

Speakers' Bureau. Dr. Hotchkiss expressed the opinion that a bureau of competent and effective speakers is needed to take medicine's message directly to the public. It was brought out that the Society has maintained a list of speakers in its files but has never established a truly organized Speakers' Bureau. The Committee agreed that the setting up of such a bureau might well be a project for Ed DeBolt. Mr. DeBolt has recently been employed as public relations and legislative campaign consultant for the Society.

Council Retreat. The Committee had been requested by Council to consider the advisability of holding a second retreat. Although everyone agreed that retreats of this type are enjoyable and have a great deal to recommend them, it was believed that such a meeting in 1976 could not be justified. There are a great many matters which must be attended to before the end of the year, and the time factor precludes such a session during the coming months. It was agreed, however, that the President should have the option of arranging a retreat at any time he believes advisable.

Tort System. The Committee was advised that changes in the tort system are being proposed all over the nation. Efforts are being made in some areas of the country to bring together representatives of interested groups for the purpose of discussing tort system reform. The Virginia Association of Professions was suggested as the organization to approach in this regard. The membership of VAP includes physicians, lawyers, dentists, pharmacists, etc. A motion requesting Dr. Hill to discuss the matter of tort reform with VAP was seconded and adopted.

Headquarters Building. The Committee learned that $75,000 is now in the Society's building fund, and the time appears to have come when serious consideration should be given to expansion of the headquarters structure. It was requested that the matter be placed on the next Council agenda.

As we conclude this report, we have one last thought to leave with you. Should there be anyone who wonders why the cost of operating the Society increases from year to year we would point out that in 1969, the membership totalled 3,600. Today that number is close to 5,600—an increase of 2,000 during the last seven years! An increase in membership means an increase in service and new demands on staff and facilities. We believe that today the Society is active in more areas and operating with more efficiency than at any time in its history. Let us keep it moving forward—and in the right direction!

William S. Hotchkiss, MD, Chairman
Harry C. Bates, MD
William R. Hill, MD
Carl E. Stark, MD
John A. Martin, MD

Joint Practice

THE JOINT PRACTICE COMMITTEE met last on February 6, 1976 and has another meeting planned for early September.

At the February meeting Dr. W. Nash Thompson, who has been the cochairman of the Committee for a number of years, submitted his resignation much to the regret of all members present as it was felt that we would all miss his leadership and devotion. Following this, C. Barrie Cook was nominated and elected to replace Dr. Thompson as cochairman.

During the past several years the committee has had numerous discussions in regard to its role and the functions it should fulfill. It has been generally felt that local joint practice committees should be formed in various areas of the state but these have met with little success except in Southwest Virginia where Dr. Thompson did have a functioning unit.

A number of requests have come recently to the Committee concerning the role of nurses in various hospital and non-hospital situations and exactly how much they should be able to do in various situations. The Committee felt that this was a worthwhile goal and at the present time is attempting to answer these questions and subsequently will report back to the state medical and nursing societies the results of their reports.

C. Barrie Cook, MD, Chairman
Charles H. Townes, MD
William E. Printer, MD
Robert F. Mann, MD
Richard A. Michaux, MD
Joseph W. Milam, MD
William M. Deyerle, MD

Maternal Health

A MEETING of the Committee on Maternal Health was held in Richmond on June 30, 1976. This meeting was held jointly with the Virginia Ob-Gyn Society, Committee on Regionalization.

The initial part of the meeting consisted of a presentation by Dr. Harold Gabel which contained a statistical review of the maternal deaths in Virginia in 1975 and a statistical survey of abortion in the United States and in Virginia for 1974. In summary, his report is as follows.

In 1975 there were nine reported maternal deaths and 69,099 births. This is an incidence of 1.3/10,000 live births, one of the lowest in our history. Of the nine deaths, six were nonwhite and three were white. The majority occurred in the age group between 25 and 29. Of these deaths, two were related to ectopic pregnancy, one to postpartum hemorrhage, two to pulmonary embolus, three to amniotic fluid embolus and one to cerebrovascular hemorrhage. Of significance is the fact that two-thirds of the deaths were related to embolic phenomenon, and there were no deaths related to toxemia or infection. Again, ectopic pregnancy is responsible for 25% of the maternal mortality in Virginia. This statistic is unchanged since the early 1960's. In this year, the number of hospital births continues to be above 99%, and the number of midwife deliveries continues to decrease and now accounts for less than 5/10 of 1% of the deliveries. The illegitimate birth rate is again 13/1,000 live births. There has been no decrease in this figure since 1970.

In 1974 there were 763,476 legal abortions in the United States. This was an increase of 24% over 1973. The national abortion rate increased from 196 abortions per 1,000 live births in 1973 to 242 abortions per 1,000 live births in 1974. This represents nearly one legal abortion for every four live births. In Virginia there were 14,372 abortions in 1974, an increase of 48% over 1973. The abortion rate was 210/1,000 live births. Women obtaining legal abortions in 1974 in the United States and in Virginia tended to be young, white, unmarried, of low parity and early in pregnancy at the time of the procedure. Suction curettage remained the predominant abortion method in 1974, accounting for 77% of all procedures, followed by sharp curettage at 12%, intrauterine instillation at 8% and major abdominal operations at 1%. Eighty-seven percent of women who underwent abortion did so during the first 12 menstrual weeks of pregnancy. This represents an increase of 25% from 1972. There were 48 deaths due to complications of abortion in 1974 in the United States. Legal abortion accounted for 24 of these 48 deaths. The death-to-case rate for



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BOBBY W. NELSON, M.D.
Associate in Psychiatry

NEUROLOGY

GERALD W. ATKINSON, M.D.
Associate in Neurology

HUGH HOWELL, M.D.
Associate in Neurology

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legal abortions fell to 3.1 deaths per 100,000 abortions in 1974, down from 3.8 deaths per 100,000 abortions in 1972. In Virginia in 1974 there were no deaths related to legal abortions; however, there were two deaths related to abortion. There were no abortion-related deaths in 1975 (legal or illegal abortions).

The next topic of discussion was the regionalization of maternity care. An effort toward organizing the obstetricians/gynecologists in Virginia and making them knowledgeable about regionalization of medical care was begun at a prior meeting in January of 1975. The Committee on Maternal Health and the Virginia Ob-Gyn Society Regionalization Committee have provided several information-disseminating conferences on regionalization of obstetric care throughout the state in the past six months. In each region of the state a small committee of local obstetricians has been organized to gather data to determine the health needs in each area and to determine what resources are available. It is hoped that when the regional Health Systems Agencies are formed, the OB committee can be appointed as a technical advisory committee to provide the data that will be needed to construct a health care plan for obstetrics. The plan can then be assured of providing high quality obstetrical services for each patient according to her need in a manner that is consistent with the health care pattern thought to be the best by local practicing physicians.

Mr. Herbert Oglesby, Director of the Division of Health Planning and Resources Development of the Virginia State Health Department, then explained what progress had been made on a federal, state and local level in terms of regionalization of medical care as a whole. Dr. David Draper, professor of pediatrics at the Medical College of Virginia, then proceeded to explain what efforts toward regionalization the Fetus and Newborn Committee had been making to insure similar goals in the effort toward regionalization of infant care by practicing pediatricians.

The members present at this meeting resolved to continue their efforts at presenting the regionalization approach to obstetrical care to local practicing physicians and other interested parties. It was also resolved that the committees would continue to gather and organize relevant data and present this data to the local Health Systems Agency when it is formed in their area of the state. Progress will be evaluated at the next meeting of the joint committee in November of 1976.

Insurance for maternity care was then discussed. Mr. Willard Osburn, of The Medical Society of Virginia, explained what procedures might be necessary to obtain health insurance for pregnant women in Virginia. He stated that at this point the outlook for providing this insurance statewide was not good. The Committee felt that lack of maternity coverage might be detrimental to maternal health care in the Commonwealth. Mr. Osburn was asked to pursue the matter.

Mr. Osburn then gave a review of legislation recently acted upon. Most of the relevant material that was dealt with pertained to malpractice insurance. He described what The Medical Society of Virginia had sought and what had been achieved for practicing physicians in the area of malpractice insurance.

A significant topic which the Committees addressed was the use of hospital obstetrical units for nonmaternity patients. The Committees felt that with adequate surveillance, scheduled minor "clean gyn" procedures could be done in the delivery room where physical arrangements permitted. This excludes hysterectomy, but includes tubal ligation and abortion. The Committees felt that such postoperative patients might be housed on the postpartum ward.

Other topics which were discussed were proposed changes in the Maternity Hospital Law to bring each hospital to an improved functional status in obstetric and newborn care, the use of an "Informed Consent" for sterilization and recertification for obstetricians/gynecologists.

Leo J. Dunn, MD, Chairman
Harold D. Gabel, MD, Secretary
Mason Andrews, MD
Thomas G. Bell, MD
Thomas P. Caine, Jr., MD
Herbert A. Claiborne, Jr., MD
William L. Driskill, MD
Rufus P. Ellett, Jr., MD
Francis G. Gentile, MD
Joseph E. Maddox, MD
John J. Marsella, MD
Francis R. Payne, Jr., MD
William N. Thornton, MD

Membership

ANOTHER NEW CHAPTER has been written and added to our membership story, this one having to do with our reaching the 5500 level. This represents a dramatic increase over the 5165 member figure reported last year. Your Committee takes this occasion to extend a warm welcome to all these new members and expresses the hope that they will take full advantage of the many services available through the state office.

We cannot help but note that the issue of "unified membership" will be decided by the House of Dele-

gates during its coming meetings in Williamsburg. Regardless of the outcome, we can report that Virginia has once again recorded an increase in AMA membership. We exceeded our 1975 record in July. This is encouraging news in these days when a united profession is vital to the preservation of our traditional freedoms.

There have been no problems referred to your Committee during the past twelve months and no formal meetings were required.

Your Committee wishes at this time to recommend our President, Dr. Raymond S. Brown, for honorary active membership in The Medical Society of Virginia. Doctor Brown has won the admiration and respect of all Virginia physicians for his tireless efforts on behalf of medicine in our Commonwealth. He was "on call" 24 hours a day during the 1976 session of the General Assembly and much of the success the Society enjoyed with respect to malpractice legislation can be properly attributed to his hard work. He has done all of us good service.

Hugh J. Hagan, MD, Chairman
James Cooper, MD
John H. Thomas, Jr., MD

Mental Health

THE MENTAL HEALTH COMMITTEE of The Medical Society of Virginia met on June 10, 1976. Mr. Willard C. Osburn, Administrative Assistant of The Medical Society of Virginia, acted as secretary. Invited guests were Dr. William Allerton, Commissioner, State Department of Mental Health and Mental Retardation, and James M. Summers, PhD, Director of Continuing Education, The Medical Society of Virginia.

There was considerable discussion of the recently enacted law authorizing the establishment of Behavioral Science Boards. It was learned that the Boards have not been formed, and the rules and regulations of the Boards will not be available until around January 1, 1977.

Dr. Summers discussed the latest developments in the Society's Continuing Medical Education Program. His report included a review of the Mandatory Continuing Medical Education and Relicensure Bills being considered by the General Assembly; the progress of the accreditation of organizations throughout the State, and the fact that the program will be similar to the AMA Physicians Recognition Award; the individual physician will be responsible for the documentation of his CME hours earned and a record booklet will be provided for this purpose; the manner in which specialty societies may qualify for the program; the manner in which these records would be sent to the Society for the award to be presented; the reviewing and certification process for the specialty society to be accredited for the program; the need for a communication network to be established for small hospitals, which may later be expanded to a statewide level; the possibility of having all specialty societies meet together during the Annual Meeting of the Society for CME purposes; two consortiums and five other organizations have been approved for CME Programs covering approximately 3,000 physicians in Virginia. After hearing the above comprehensive report, the Mental Health Committee gave it tactical approval.

The latest developments in the PSRO situation throughout the state was brought to the Committee by Mr. Osburn. He reported that the Society was to take the position of having one central PSRO in the state consisting of five regional areas. At the time of the writing of this report, the PSRO is operating as five separate organizations with a single support center.

Dr. Allerton began his comments to the Committee by discussing the latest status of the Health Systems Agencies. All of the HSA's in Virginia have one mental health representative (Chapter 10) but only one psychiatrist as a representative. Unfortunately, the State Health Coordinating Council does not have a single psychiatrist as a member. The Committee was unanimous in its opinion that recommendations should be made that a psychiatrist be appointed to the Council. The Committee also passed a motion recommending to the MSV Council that they recommend that a psychiatrist be appointed to the overall Behaviorial Science Board which is soon to be formed.

Dr. Allerton also discussed the new statutes enacted by the last General Assembly dealing with the admission of children to a psychiatric facility. If a child is over seven years of age and the parents want him admitted and if the child does not object, there would be no problems for the admission. Otherwise, if the child objects to admission, a court hearing would have to be held. If a child were under seven years of age, a court hearing automatically would be needed.

Dr. Allerton reported that the Hopkins Report recommended that Medicaid be placed under other economic assistance programs. The Committee unanimously passed a motion asking the Society to oppose combining Medicaid under other economic assistant programs.

The Committee was glad to learn from Dr. Allerton that the 48-hour detention period for patients suspected of being mentally ill and awaiting a judicial

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Daniel A. McKeever, III, Ph.D.
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Jerrold L. Zimmerman, M.S.W.
Psychiatric Social Worker

Gerardo A. Crichigno, M.D.
Director, Outpatient Services

Richard B. Zonderman, Ph.D.
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Henry E. Morris, Jr., M.S.W.
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Adele I. Karp, M.S.W.
Psychiatric Social Worker

Myriam C. Cain, M.S.W.
Psychiatric Social Worker

Arnold F. Strother, M.D.
Clinical Associate

Frances M. Lockwood, Ph.D.
Clinical Psychologist

Marilyn T. Sokolof, Ph.D.
Clinical Psychologist

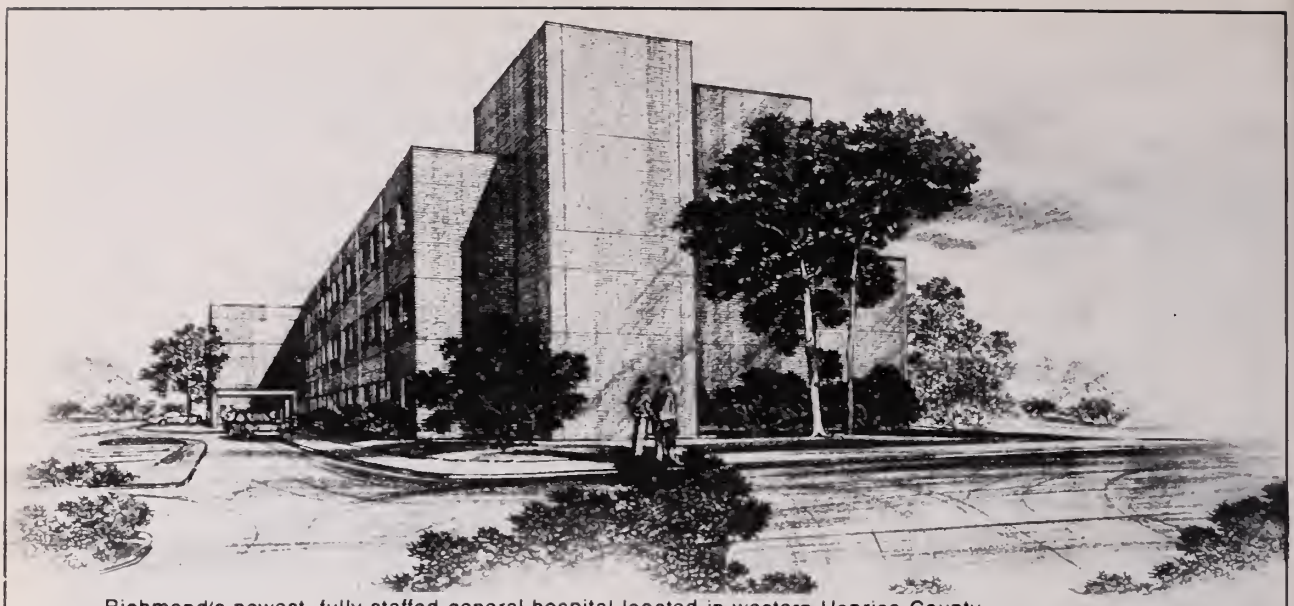
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hearing had been extended to 72 hours on weekends and holidays.

Dr. Allerton heard a complaint from a member of the Committee concerning insurance payments being referred to the state institution rather than to the original referring physician. Dr. Allerton assured the Committee that every effort is being made to refer these payments back to the physician and that the individual complaints should be registered with the Department of Mental Health and Mental Retardation for prompt attention.

Mr. Osburn provided the Committee with details of the malpractice legislation enacted during the 1976 Session of the Virginia General Assembly. Of particular interest to the Committee was the fact that copies of hospital records or papers shall be furnished at a reasonable charge to the patient or his attorney provided, however, that "copies" of a patient's mental records shall not be furnished such patient where a written statement that, in his opinion, the furnishing to or review by the patient of such records would be injurious to the patient's mental health or well being; but in any such case, such records shall be furnished to the patient's attorney.

The Committee reviewed efforts of other Society programs throughout the country which involves the provision for identification, counselling, monitoring of treatment and assistance in rehabilitation and reentry into practice for the impaired physician. The Committee recommends that The Medical Society of Virginia institute a similar program following AMA guidelines.

The Chairman wishes to express to the remainder of the Committee and to Mr. Robert I. Howard, Executive Vice-President of the Society and to Mr. Osburn his appreciation for their cooperation in the formulation of this report.

John R. Saunders, MD, Chairman
W. D. Buxton, MD
Emory F. Hodges, Jr., MD
John O. Hurt, Jr., MD
Asad Masri, MD
Morgan Scott, MD
Robert H. Thrasher, MD
R. Terrell Wingfield, MD

Regional Medical Program

Effective September 30, 1976, the Virginia Regional Medical Program will complete its final and fiscal phase-out. A few projects will continue until their respective termination. The State Health Department has assumed responsibility for serving as the fiscal agent and program director until these projects are terminated, no later than March, 1976.

Since there is no further need for this committee, the undersigned recommends that it be removed as an ad hoc committee.

Frank Alton Wade, MD, Chairman

Pharmacy

The pharmacy committee met on December 4, 1975, with these members present: Drs. George A. Reynolds, Robert L. Glenn, Herman N. Nachman, Frank N. Bilisoly, Marvin L. Weger and Lloyd T. Griffith, Chairman. Guests of the committee were Dr. Everett L. Coffey, a family practitioner from Buchanan, Virginia, and Dr. Samuel C. Kaim of the National Pharmaceutical Council. Dr. Coffey appeared in his own behalf seeking relief from a Board of Medicine ultimatum that he immediately cease dispensing drugs to his patients, a practice that he had followed for 21 years, and rid his office of prescription drugs within 90 days or surrender his license to practice medicine. Dr. Coffey practices in Buchanan, which has a population of slightly more than the maximum of 1,000 allowed by the Board of Pharmacy in granting permits to physicians to dispense. Dr. Coffey testified that he was the only reliable source of prescription drugs in his town but was unable to obtain legal relief from either the Board of Pharmacy or the Board of Medicine. The Pharmacy Committee was in sympathy with Dr. Coffey's situation but powerless to aid him in view of the statutory provision in the Virginia Drug Control Act that states that a physician must practice in a town of less than 1,000 population in order to be licensed by the Board of Pharmacy for dispensing.

The Committee discussed the proposed repeal of the anti-substitution legislation and the pro-substitution legislation sponsored in the Virginia legislature by Del. Samuel Glasscock. The numerous detriments of pro-substitution and formulary legislation both to the practice of medicine and the public interest were discussed, with many insights provided by Dr. Kaim and members of the committee.

As a result of the meeting, the following recommendations were made:

1. That there be an effort by The Medical Society of Virginia to raise the numerical population figure to enable a physican to be legally permitted by the Board of Pharmacy to dispense medications to his patients.

2. That The Medical Society of Virginia oppose any formulary or pro-substitution bill and oppose

repeal of the anti-substitution statute now in existence.

3. That the committee recommend that Dr. Herman Nachman and staff members represent the Society before legislative hearings.

4. That the Medical Society make every effort to continue to oppose the aggressive attack by certain elements in pharmacy and the continued effort by these pharmacy elements to infringe on the practice of medicine.

Lloyd T. Griffith, MD, Chairman
George A. Reynolds, MD
Robert L. Glenn, MD
Herman M. Nachman, MD
Frank N. Bilisoly, MD
Marvin L. Weger, MD

Public Relations

WE ARE PLEASED to report that thanks to the assistance and cooperation of the MSV leadership and membership and that of the many medical auxiliaries around the state, The Medical Society of Virginia was able to obtain significant remedial medical malpractice insurance legislation in the 1976 Virginia General Assembly.

Hundreds of our members participated in our legislative campaign by writing letters and sending telegrams and personally contacting both legislators and patients for support of the MSV proposal. Our special thanks go to the officers, councilors and vice-councilors, Auxiliary presidents, and such members as Dr. Charles Davis, Dr. Jack Woodside, Dr. William Barney, Dr. Gene Stevenson and many others who contributed their time and efforts.

We retained Ed DeBolt and his public relations firm to assist us in promoting public education on the problem and in seeking a legislative resolution from the General Assembly.

As part of our effort, we established an extensive system of constituent lobbying to work in conjunction with the legislative professionals at MSV. We estimate that several thousand letters and over 1,000 telegrams were sent in support of remedial medical malpractice insurance legislation to members of the General Assembly as part of this program.

Other programs initiated to generate public support for our position included:

- A massive direct mail campaign comprised of a letter seeking public support and a brochure containing important information about the problem, these sent to over 200,000 Virginians.
- A program to provide speakers to address influential groups around the state on the problem of medical malpractice insurance.
- A system to ensure that at every hearing or public forum on malpractice The Medical Society of Virginia position would be well represented. At the initial joint committee hearing in Richmond in February over 200 MSV supporters attended.
- Periodic press conferences and press releases to call attention to the problem.
- Mobilization of medical auxiliaries and other health care provider groups to write letters to legislators. The auxiliaries produced approximately 2,000 individually written letters.

These were but a few of the programs instituted from October through March.

While we did not get everything we wanted from the 1976 General Assembly, we feel that we did make substantial gains and particularly increased the awareness of legislators as to the impact the Society can make.

In final form, the legislation we gained (SB-115) contained: a) the medical review panel, with three health care providers, three attorneys and a sitting judge; b) voluntary binding arbitration provisions for the panel; c) immunity provision for medical staff review committees; and d) a $750,000 limitation to go into effect April 1, 1977. This time was added to make possible a court test of constitutionality before the State Corporation Commission and the Virginia Supreme Court. The final version passed the Senate 39-0 and the House 70-4.

We anticipate another tough battle in 1977 and are planning strategy and preparing for it now.

Harold I. Nemuth, MD, Chairman
Arthur M. Martin, Jr., MD
William H. Barney, MD
Nelson M. Smith, MD
Humberto M. Albuerne, MD
Jack R. Woodside, MD

Rehabilitation

THE PRIMARY ACTIVITY of the Rehabilitation committee is to provide consultation and assistance to the Virginia Department of Vocational Rehabilitation regarding medically related matters.

The Committee met at the Woodrow Wilson Rehabilitation Center, Fisherville, Virginia, on Sunday, November 9, 1975, with nine of the 16 members present. Also attending this meeting were representatives from the Department of Vocational Rehabilitation.

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James R. Wickham, M.D.
Snowden C. Hall, III, M.D.

Obstetrics and Gynecology:
Spotswood Robins, M.D.
David C. Forrest, M.D.
Joseph C. Parker, M.D.
William M. Oppenhimer, M.D.

Orthopedics:
Beverley B. Clary, M.D.
James B. Dalton, Jr., M.D.
Franklin P. Watkins, M.D.

Pediatrics:
Thomas P. Overton, M.D.
Edward J. Wiley, M.D.

Roentgenology and Radiology:
Hunter B. Frischkorn, Jr., M.D.
William C. Barr, M.D.
John E. Reed, M.D.

Anesthesiology:
William B. Moncure, M.D.
Heth Owen, Jr., M.D.

Surgery:
Richard A. Michaux, M.D.
Carrington Williams, Jr., M.D.
Armistead M. Williams, M.D.
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Wyatt S. Beazley, III, M.D.

Urological Surgery:
Frank Pole, M.D.
Harry S. Rowland, Jr., M.D.

Plastic Surgery:
Hunter S. Jackson, M.D.

Ophthalmology, Otolaryngology:
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The Committee received a report from the ad hoc committee on outpatient cardiac catheterization. On the basis of this report the Committee recommended to the Department that it should not sponsor outpatient heart catheterization.

The Committee recommended to the Department that it adopt for its radiological fee schedule the coding system utilized by the Blue Cross. A number of additions and changes in the vocational rehabilitation medical fee schedule were also recommended.

The Committee established two ad hoc committees which are to report at the next meeting of the full Committee. One ad hoc committee is to develop recommendations for the payment by Vocational Rehabilitation for services of assistant surgeons, and the other is to provide guidelines for the utilization and payment for services of the internal medicine specialists and family practice specialists.

Considerable advice and consultation relative to securing medical consultants has been provided to the Disability Determination Division of the Department of Vocational Rehabilitation. This activity was necessary as a result of their recent decentralization.

The Committee also has discussed and provided consultation to the Department regarding many other medically related problems. Throughout the year individual members of the Committee have been called upon by the Department for assistance and consultation regarding problems related to their medical speciality.

Alexander McCausland, MD, Chairman
Thomas Apostle, MD
Charles Duncan, MD
Robert J. Faulconer, MD
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Frank A. Strickler, MD
David K. Webster, MD

Sports Medicine

THE SPORTS MEDICINE COMMITTEE continues to progress in its efforts to reduce injuries among the athletes of Virginia. Primary attention at our Homestead meeting, April 24, 1976, focused on the high school athlete in the following areas:

1. Continued liaison with Virginia High School League.
2. Continuation of medical programs given at the Annual Virginia Coaches Clinic held in Roanoke area in July of 1976. Dr. Ripley has organized this program.
3. Increasing emphasis on regional sports medicine programs; direct contact has been made in various regions for initiation of such a program.
4. Increasing efforts to obtain certified trainers for each high school.

Robert P. Nirschl, MD, Chairman
Gervas S. Taylor, Jr., MD
Richard N. Fisher, MD
Frank C. McCue III, MD
Oscar W. Ward, Jr., MD
J. Thomas Hulvey, MD
James B. Jones, MD
Joel A. Mason, MD
Richard Bullock, MD
H. C. Alexander III, MD
Louis P. Ripley, MD
Virgil May, MD

Highway Safety

A BILL to repeal the motorcycle helmet law is expected to be introduced in the 1977 Legislature. Since approximately 50% of motorcycle fatalities are due to head injuries, this Committee strongly opposes such a bill and will request the Society to pass a resolution clearly stating the opposition.

Senate Bills 150 and 141 enabling physicians to report to the State Department of Health any patient thought to be physically or mentally impaired as a motor vehicle operator have been carried over to the 1977 Legislature. These bills also provide immunity from civil or criminal liability. This Committee feels these bills are definitely in the interest of highway safety and asks the Society to support them.

The safety belt interlock system was installed in 1974 automobiles but was removed the following year because the Senate and House passed a bill allowing automobile manufacturers to delete this device. It is the opinion of this Committee that this device would have significantly lowered our death and injury rates, and we respectfully request the Society to pass a resolution to be sent to the Department of Transportation, supporting the interlock system.

There is a great need for all physicians to acquaint themselves with knowledge regarding infant and child seat restraints so that they may properly advise

and encourage their patients to utilize proper restraints. Such information can be obtained from Physicians For Automotive Safety, 16 Hobart Gap Road, Short Hills, New Jersey 07078. Patient brochures entitled "Automotive Baby Care" are available from this source.

Robert W. Waddell, MD, Chairman
James C. Andrews, MD
N. Turner Gray, MD
David K. Webster, MD

Virginia Medical Monthly

THE PAST YEAR brought many changes to the *Virginia Medical Monthly*. Our longtime Editor, Dr. Harry J. Warthen, retired, as did our faithful Managing Editor, Miss E. Spencer Watkins. Then, pressed by escalating print costs, a more favorable contract was negotiated with the William Byrd Press, Richmond; when the transfer was made, with the August, 1976, issue, the cover and interior styling of the journal was revised.

In 1918, when The Medical Society of Virginia bought and began publishing the journal, the print order was for 2,250 copies. This year that order passed the 6,000 mark, graphic indication of the growth of the membership.

On the other hand, our 4-color insert advertising pages are declining. For the first six months of 1976 the journal carried only 40 pages of these insert ads, as compared with 69 pages for the same period 1975. We have been fortunate in obtaining some additional "local" advertising to compensate partially for this loss; but the total of ad pages January through July shows an unhappy decrease nonetheless: 249 pages for the period in 1975, 228 1/4 for the same period 1976.

We continue to receive for publication a highly gratifying number of excellent manuscripts dealing with medicine, history and literature. The Editorial Board's contributions bring particular merit to our pages. A healthy development is the marked increase in the submission of articles of opinion and Letters to the Editor. The support of these contributors is the measure of the journal, and the Editor greatly values the intelligence and energy of their expressions.

W. T. Thompson, Jr., MD, Editor

Virginia Hospital Advisory

A SPECIAL meeting with representatives of the Virginia Hospital Association was held in Richmond on December 17, 1975, for the purpose of discussing certain aspects of the malpractice situation.

The meeting was especially interesting since Mr John G. Day, Commissioner of Insurance, discussed in detail his hospital-based malpractice cost distribution proposal. He assured everyone that he was approaching the meeting with a completely open mind Mr. Day indicated that he does not view his plan as a final solution to the problem but rather as a temporary measure until something of a permanent nature can be worked out.

The Commissioner suggested that the age old problem of communication might well be one of the main causes of the malpractice problem. He offered several examples by way of illustrating his point.

The value of arbitration was discussed at some length, and it was indicated that support for this approach might be obtained if some guarantee could be offered as to the availability of expert witnesses.

The advisability of organizing a captive insurance company was discussed, and it was the consensus that all concerned should look twice before moving in that direction.

The advisability of seeking some solution patterned after Workman's Compensation was also discussed. It was pointed out, however, that it would be almost impossible to put together a bill at this late date worthy of the support of the General Assembly in 1976. It was agreed that the idea should not be abandoned completely.

The Committee is most appreciative of the wonderful cooperation it continues to receive from its counterparts in the Hospital Association. There is no doubt that most of our problems are of a mutual nature and can be solved by sitting down and working them out together.

James Asa Shield, MD, Chairman
Richard F. Clark, MD
John T. Myles, MD
F. Ashton Carmines, MD
Gerald J. Fisher, MD
Josiah T. Showalter, MD

The Bicentennial Exhibit

THREE YEARS AGO The Medical Society of Virginia appointed a Bicentennial committee to prepare a medical exhibit depicting the role of Virginia physicians during the American War for Independence. The Society designated $2,000 for this purpose. At the suggestion of the Society, the Richmond Academy of Medicine appointed a similar committee with Dr. E. Randolph Trice as chairman to work with the

tate Society in furthering this joint endeavor. The Academy designated a modest sum to aid in the preparation of the exhibit and contributed the use of the east room on the first floor of their building for the exhibit.

The next problem—that of raising sufficient funds to prepare a representative exhibit—was solved when Dr. Trice approached the A. H. Robins Company for aid in the financing of the project. This was agreed to by Robins, and well over $20,000 has been contributed by the company for this purpose. Your Committee asked the firm of Design and Production, Inc., of Alexandria, to aid in the preparation of the exhibit. This company was thoroughly familiar with patriotic exhibitions of this type, for they prepared the Alexandria, Williamsburg-Yorktown, Charlottesville and Smithsonian Institution exhibits now on display.

Our exhibit, captioned "Virginia Medicine in the War for Independence," opened on June 7. This date was chosen because it marked the 200th anniversary of the introduction of the resolutions in the Second Continental Congress by Richard Henry Lee of Virginia, which resulted in the Declaration of Independence four weeks later. The exhibit has been publicized on TV and in the press by the Martin Public Relations Agency of Richmond.

The exhibition is dedicated to the 230 Virginia physicians and surgeons who served in the Continental and Virginia forces. Dr. Rickman and later Dr. McClurg, who served as Director and Chief Physician of the Continental Hospitals in Virginia, are featured. The hardships and handicaps under which physicians and patients alike served are depicted. Virginia's pioneer and humane role in the care of the insane is emphasized. Revolutionary War medical instruments and artifacts are on exhibit. Early pharmaceuticals and their preparation were presented by Dr. Milton Neuroth of the Medical College of Virginia. Public health methods, which were virtually nonexistent in 1776, are contrasted with present-day precautions. The incomparable Miller collection of medical silhouettes of the Revolutionary period are displayed. It is hoped that this exhibit may be kept intact during the entire Bicentennial era (1976-1981) and perhaps exhibited in other cities in the state during this five-year period.

One problem has arisen and continues to plague the Committee. Our original plans anticipated volunteer hostesses from the local and state auxiliaries. When the exhibit opened in June, hostesses from Richmond were available for the first two weeks only. The coverage since June 21 has been by paid attendants at the minimal scale of $2.30 per hour, which amounts to $13.20 per day or $82.80 per week. The Medical Society of Virginia has been carrying the cost so far. During its May meeting, the Council of the Society moved to extend this financial coverage until the Annual Meeting in Williamsburg in November. A decision regarding this matter must be reached by the House of Delegates at that time. It is earnestly hoped that additional sources of revenue for this purpose will be available prior to the fall meeting, but at the time of this writing, The Medical Society of Virginia is carrying the entire cost.

Your Bicentennial Committee takes this opportunity to thank the Society for the opportunity to prepare this worthwhile and patriotic display, which doubtless will make the public aware of the vast advances made by American medicine during the past 200 years and the role played by Virginia physicians during the Revolution.

Meanwhile, members of the Society are urged to visit the exhibit at the Richmond Academy, 1200 East Clay Street; it is open from 10 to 4 o'clock, Monday through Saturday.

Harry J. Warthen, MD, Chairman
Malcolm H. Harris, MD
Robert I. Howard
John P. Lynch, MD
James L. Moore
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Fred J. Spencer, MD

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MEETINGS ABOUT MEDICINE

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September

Research and the Practice of Medicine in 1976, sponsored by the National Institutes of Health and the Medical Society of the District of Columbia. Sheraton Park Hotel, *Washington DC* and the National Institutes of Health, *Bethesda MD,* September 16-18. Miss Beth Custer, Medical Society of DC, 2007 Eye Street NW, Washington 20006.

21st Annual Angus M. McBryde **Perinatal** Symposium, sponsored by Division of Perinatal Medicine, Duke University Medical Center, *Durham, North Carolina,* September 15-16. Angus M. McBryde Perinatal Symposium, Box 3967, Duke University Medical Center, Durham 27710.

2nd Annual Postgraduate Course in **Adolescent** Medicine, sponsored by the Section of Adolescent Medicine, Medical College of Virginia, Richmond Hyatt House, *Richmond,* September 16–18. George M. Bright, MD, Box 151, MCV Station, Richmond VA 23298.

Diabetes 1976, sponsored by Division of **Endocrinology** and **Metabolism** and Department of Continuing Education, MCV, Medical College of Virginia, *Richmond,* September 23. Department of Continuing Education, School of Medicine, MCV, Box 91, Richmond 23298.

October

Perspectives in **Pediatrics** #2, sponsored by Department of Pediatrics, University of Virginia School of Medicine, *Charlottesville,* October 14. Office of Continuing Medical Education, Charlottesville 22901.

Neurology for the Practicing Physician, sponsored by Department of Neurology, University of Virginia School of Medicine, *Charlottesville,* October 15-17. Office of Continuing Medical Education, Charlottesville 22901.

opics in **Gastroenterology** and **Liver Disease:** Medical and Surgical Aspects, sponsored by the Departments of Medicine and Surgery of The Johns Hopkins School of Medicine, Johns Hopkins Medical Institutes, *Baltimore,* October 7-9. Willis C. Maddrey, MD, Blalock 932, The Johns Hopkins Hospital, Baltimore 21205.

iabetes Day, sponsored by National Institutes of Health, Masur Auditorium, NIH Clinical Center, *Bethesda, Maryland,* October 16. Jesse Roth, MD, Diabetes Branch, NIH Clinical Center, Room 8S-243, Bethesda 20014.

High Risk **Obstetrics** and **Gynecology,** sponsored by Department of Obstetrics and Gynecology, University of Virginia School of Medicine, *Charlottesville,* October 22. Office of Continuing Medical Education, Charlottesville 22901.

November

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December

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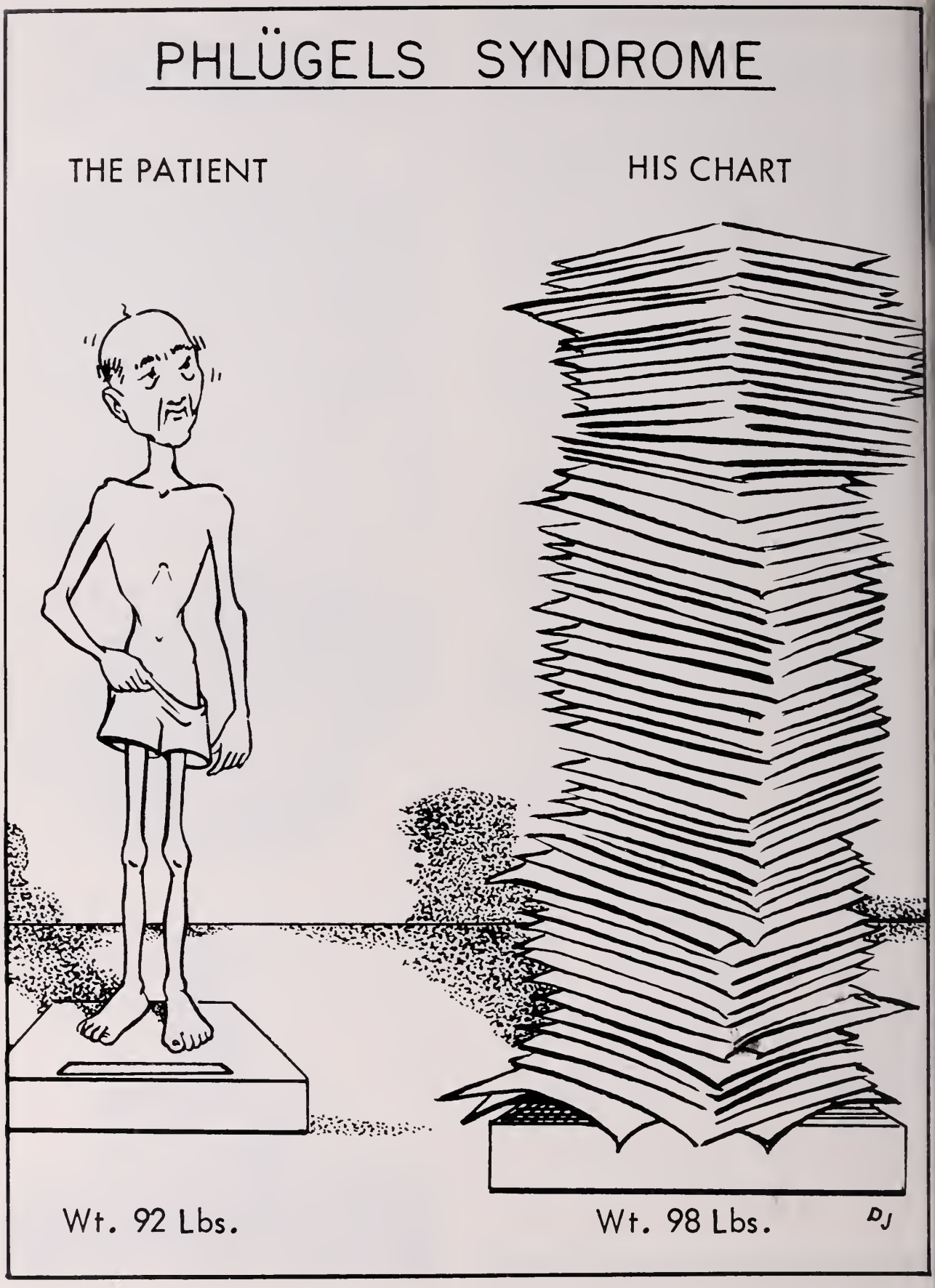
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VIRGINIA MEDICAL

EDITORIAL

The Editor Inaugurates a New Cartoon Feature

OUR URBANE, ubiquitous, former MCV-VCU dean now VA savant, Professor Kinloch Nelson of the inscrutable smile, submits the cartoon on the opposite page, saying, "I am sending along a cartoon of a syndrome that is increasing by leaps and bounds."

This inaugurates a medical cartoon feature which will provide recognition for the author-artist and pleasure for our readers.

Put your mind and your hand-eye coordination to work. Collaboration between separate owners of minds and fingers is quite acceptable. While original cartoons are preferred, notable ones from other publications may be submitted, provided the copyright requirements are met.

W.T.T.

Tribute to a Life of Richness and Rarity

AFTER TWENTY-FIVE YEARS of distinguished service to the University of Virginia Medical Center, Dr. Edward P. Cawley relinquished the Chair of Dermatology on June 30. To honor his outstanding contribution to his specialty, a fund has been raised with which to establish the Edward P. Cawley Chair of Dermatology. Those whose generosity and effort provided the fund include former residents, patients, friends and these pharmaceutical manufacturers: Barnes-Hind; Dermik, Herald, Johnson & Johnson, Lederle, Neutrogena, Owen, Scherring, Squibb, Stiefel, Syntex, Texas Pharmacal and Westwood.

A native of Michigan, Dr. Cawley received his undergraduate, medical and graduate education in dermatology at the University of Michigan. In World War II he served as a medical officer with the Third Armored Division, First Army, attaining the rank of major. In 1951 he succeeded the late Dr. D. C. Smith, who founded the University of Virginia's Department of Dermatology in 1924, making it one of the oldest such departments in the United States. During his tenure, Dr. Cawley has raised the department to one of preeminence in the specialty.

Dr. Cawley has served as chairman of the Sections of Dermatology of the American Medical Association and of the Southern Medical Association; president of the American Academy of Dermatology, the American Dermatological Association, the American Society of Dermatopathology, the American Board of Dermatology, the Southeastern Dermatological Association and the Association of Professors of Dermatology.

In addition to establishing a notable achievement record in teaching and in clinical and laboratory research, Dr. Cawley has conducted a large consulting practice, which has kept him in close touch with the problems of patient care and the needs of the practicing physician. As professor of dermatology he will remain active in teaching, research and practice. For Ed Cawley and his gracious wife, Virginia, life will continue to be both luminous and productive.

The University is fortunate in retaining Dr. Peyton E. Weary, the present professor of dermatology, who will succeed Dr. Cawley as chairman of the department.

The establishment of the Edward P. Cawley Chair of Dermatology at the University of Virginia is a tribute to one whose life has been of extraordinary richness and rarity, characterized by great warmth and a certain sense of style. Moreover, the founding of this Chair will maintain the position of the department as one of first rank in the specialty and one of which the University, the Commonwealth and, indeed, the nation can well be proud.

William H. Kaufman, MD, *Roanoke, Virginia*

Doctor Palmer: Third Virginian to Be AMA President

IT IS A GREAT PLEASURE to publish in this issue the presidential address of Dr. Richard E. Palmer, proudly recognizing the inauguration of this distinguished Virginian as President of the American Medical Association. Dr. Palmer is the third Virginian to be elevated to the presidency of the AMA, thus joining the illustrious company of Dr. Hunter Holmes McGuire of Richmond and Dr. Walter B. Martin of Norfolk.

Dr. Palmer's leadership ability has been recognized by virtually all of the organizations he has served. At George Washington University, his alma mater, he is clinical professor of pathology, has been President of the Medical Alumni Association and has received the Medical School Alumni Achievement Award. He was president of the Alexandria Medical Society in 1955 and The Medical Society of Virginia in 1964 and held many key positions in the American Medical Association before being elected president. He was president of the medical staff of the Alexandria Hospital in 1953 and has been a leader in many medical and nonmedical community affairs. He has also been recognized on the national level by organizations other than the AMA. He was president of the American Society of Clinical Pathologists in 1964 and of the International Academy of Pathology in 1974. He also received the Distinguished Service Award from the College of American Pathology in 1974. He is a member of a number of other local, regional and national societies and boards. He has contributed many articles to medical journals. Last but not least, he served as a delegate-at-large from Virginia to the National Republican Convention in 1972.

His address is commended to your careful consideration. Its message is one of hope and of inspiration. He harks back to Jefferson's credo, which he enunciates as hope based on reason and on faith in one's fellow man. Quoting Jefferson, he sums up the effect of a dogmatic, nonperceptive government on the practice of medicine: "Was the government to prescribe to us our medicine and diet, our bodies would be in such keeping as our souls are now." Our answer to misguided bureaucracy, he says, is to fight "with the gunfire of Jeffersonian reason," and to join ranks through our constituent societies and the AMA in order to present an effective, united front. Finally, he urges us "to strive, to seek, to find, and not to yield."

Dr. Palmer, we salute you. You have brought honor to yourself, to Virginia, and to this Society.

W.T.T.

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VIRGINIA MEDICAL OBITUARY

Marion Stevenson Fitchett, MD

Dr. Marion Stevenson Fitchett, Norfolk, who had practiced internal medicine in Norfolk for 57 years, died March 9 in a Norfolk Hospital. He was 86 years old.

A native of Northampton County on Virginia's Eastern Shore, Dr. Fitchett took his medical degree from the University of Virginia in 1915. He interned in the University hospital and served in the Army Medical Corps in World War I before establishing his Norfolk office. He held staff positions at DePaul, Norfolk General and Leigh Memorial hospitals and was a consultant to what is now the US Public Health Service Hospital. A member of the Medical Society for 60 years, Dr. Fitchett also was a longtime member of the American Medical Association and the American College of Physicians.

Dr. Fitchett's survivors include a son, Claiborne W. Fitchett, MD, Norfolk.

Cyril Iredel Sease, MD

At 86 years of age, Dr. Cyril Iredel Sease, Richmond surgeon, died June 29 in a Richmond hospital. Dr. Sease was president of the Retreat for the Sick Hospital at his retirement in 1970.

A native South Carolinian, Dr. Sease was graduated from the Medical College of Virginia. He practiced first in Pennsylvania, then returned to Richmond to establish an office. His membership in The Medical Society of Virginia spanned 57 years, and he belonged also to the American Society of Abdominal Surgeons and the American Medical Association.

Dr. Sease was an accomplished violinist. He played for a time with the Richmond Symphony Orchestra and built violins at his home.

He is survived by his wife, three daughters, and three sons who practice together as physicians in Harrisonburg: Dr. Cyril I. Sease, Jr., Dr. Robert T. Sease, and Dr. James R. Sease.

Oscar W. Ward, Sr., MD

At 94 years of age, Dr. Oscar W. Ward, Sr., longtime general practitioner in Hampton, Virginia, died June 19 in a Hampton hospital of adenocarcinoma of the colon. He had continued resolutely to treat his patients until a few weeks before his death.

Dr. Ward was born in Chowan County, North Carolina. He attended Wake Forest College, was graduated from the Medical College of Virginia in 1910, and trained at Sarah Leigh Hospital, Norfolk. He opened his office in what was then the town of Phoebus and is now a part of Hampton, travelling by horseback, horse-drawn buggy, bicycle and boat to visit his patients in the surrounding counties. Sixty-five years later, in August of last year, he was still keeping regular office hours, including night schedules three days a week and hospital rounds.

He served as president of the Hampton Medical Society, the Peninsula Academy of Medicine, and the staff of Hampton General Hospital, formerly Dixie Hospital. Both The Medical Society of Virginia and the American Medical Association gave him 50-year pins in 1961.

Dr. Ward is survived by his wife, a daughter, and a son, Dr. Oscar W. Ward, Jr., of Hampton.

Thomas Foster Wheeldon, MD

At 84 years of age, Dr. Thomas Foster Wheeldon died June 23 at his home in Richmond, Virginia. He was an orthopedic surgeon, and advocate of assistance to crippled children and a botanist of reputation.

Born in Missouri in 1892, Dr. Wheeldon was graduated from the University of Missouri and took his medical degree at the Harvard Medical School. He established his practice in Richmond in 1922, maintaining it until his retirement in 1975. He had been a member of The Medical Society of Virginia for 55 years and was a member also of the American College of Surgeons, the American Rheumatism Association and the International College of Surgeons.

Dr. Wheeldon won much praise for his work in organizing and operating 13 clinics to serve crippled children in Virginia and North Carolina, and he served on the orthopedic advisory committee of President Franklin D. Roosevelt's Warm Springs Foundation in Georgia.

He brought great energy to the cultivation of a botanical garden at his home; at one time it contained 200,000 azaleas of 1,800 varieties. He was gifted also

in the horticulture of rhododendrons and organized the Mid Atlantic chapter of the American Rhododendron Society, serving as its president for ten years.

Dr. Wheeldon is survived by his wife and three daughters.

L. Bradford Waters, Jr., MD

Dr. Luther Bradford Waters, Jr., Lynchburg, Virginia, died June 17 at the age of 61 years.

Dr. Waters was a radiologist. He was graduated from the Medical College of Virginia, class of 1941, and took his training at the Norfolk General Hospital and the Duke University Hospital, Durham, North Carolina. He had been a member of The Medical Society of Virginia for twenty years.

Angelos Kapsalas, MD

Notification is received of the death in January of this year of Dr. Angelos Kapsalas, Richmond psychiatrist, at the age of 42 years. Dr. Kapsalas received his medical degree at the National University of Athens, Greece, and trained at Johnston-Willis Hospital and the Medical College of Virginia Hospitals, Richmond.

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WHO'S WHO IN VIRGINIA MEDICINE

The pages of a recent JAMA issue presented an article coauthored by **Dr. William W. Gough,** *Norfolk*; **Dr. John S. Davis IV,** *Charlottesville*; and Dr. Peter M. Levitin, Greensboro, North Carolina. Its title: "HLA-B27 Antigen in Women with Ankylosing Spondylitis." The three men studied 27 female patients and found the same high association of ankylosing spondylitis with HLA-B27 antigen as that reported previously in predominantly male studies.

Dr. Maurice Nottingham, Jr., *Richmond,* a cardiologist, recently was elected president of the Richmond Area Chapter of the American Heart Association. **Dr. Fred D. Robinson,** *Midlothian,* was elected vice president.

Coauthor of an article recently published in the *Southern Medical Journal* is **Dr. Robert E. Morton,** *Falls Church.* The title, "Systemic Lupus Erythematosus: Unusual Presentation with Gastric Polyps and Vasculitis." Dr. Morton's coauthors are two physicians from Florida, Allan I. Miller and Richard Kaplan of Miami.

And MSV member **Dr. George R. Hanna,** *Charlottesville,* is coauthor of another article published in the *Southern Medical Journal,* "Associated Systemic Factors in Cerebrovascular Ischemia." This is a one-year study revealing, the article concludes, that brain ischemia is more commonly precipitated by systemic illness than usually supposed, particularly transient ischemic attacks of the vertebrobasilar circulation and completed infarcts in the carotid distribution, with cardiac disorders outnumbering all other precipitating events. Dr. Hanna's coauthors are Drs. Philip A. Singer and Ronald E. Wasserman, also of Charlottesville.

A review by **Dr. William M. O'Brien** of the Internal Medicine Department, University of Virginia School of Medicine, *Charlottesville,* appears in a recent issue of The Upjohn Company's publication INFLO. It is titled "Asthma Problems Induced Via Use of Nonsteroidal, Anti-Inflammatory Agents," and concludes: "Whatever the cause of the syndrome [acute asthma attack], aspirin and other nonsteroidal agents should be given with caution to patients with a history of rhinitis or asthma. The appearance of asthma in a rheumatoid arthritic patient should suggest that it may be drug related. Studies of pulmonary functions before and after rechallenge with a given drug should be performed to document the relationship of medication to the bronchospastic attack."

Dr. James D. Kitchin III, *Charlottesville,* was interviewed for a story in a recent issue of *HOPE News,* the publication of Project HOPE, about his service as a HOPE rotator-physician. Dr. Kitchin, endocrinologist and associate professor in the ob/gyn department at the University of Virginia, has served three tours as a rotator. His first was in 1968 aboard the SS HOPE during its mission to Ceylon; in 1972 he served for two months in a land-based program in Natal, Brazil; and last year he returned to Natal for a similar period.

The interview reveals that Dr. Kitchin's experience has made him a strong advocate of Project HOPE and its rotator-physician program. "It's very important to have people going in with fresh perspectives," he is quoted as saying. He describes his teaching (lectures, seminars and case presentations to students and residents) and the individual exchange with physicians of the host country.



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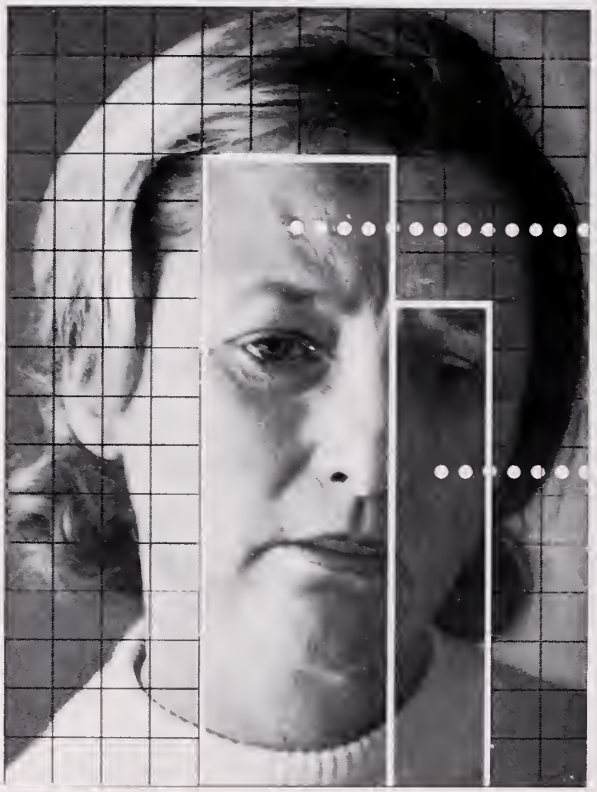
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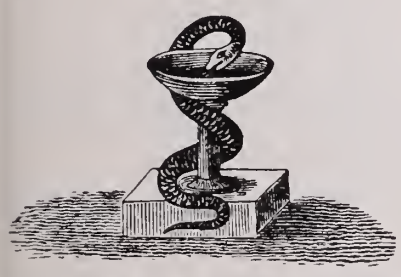
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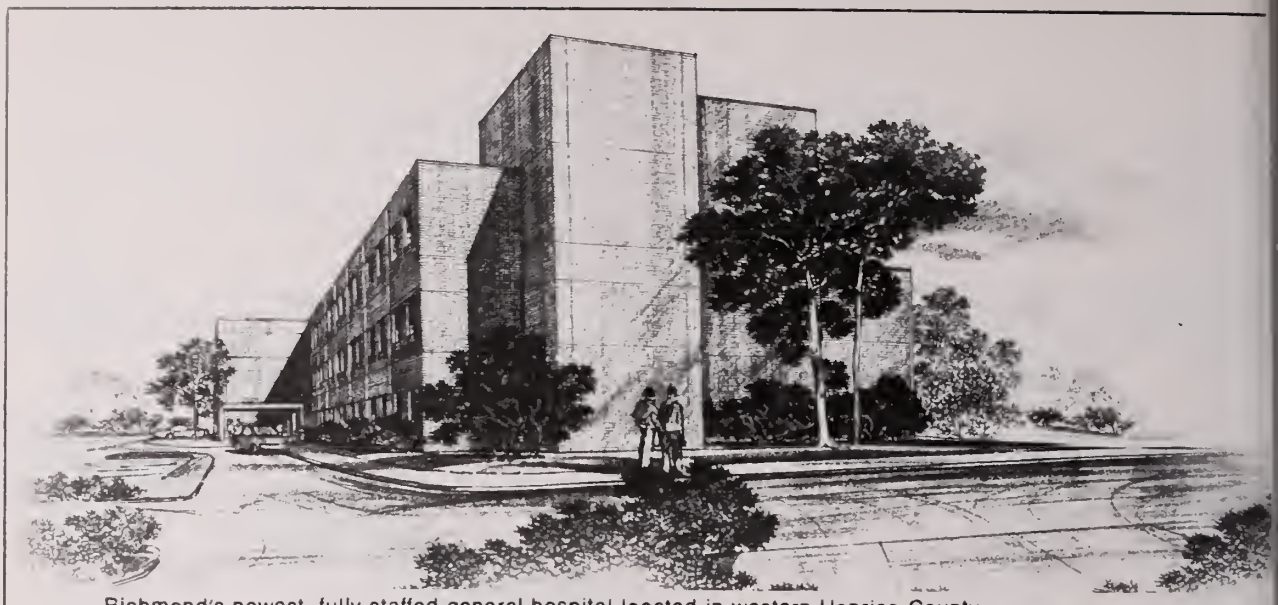
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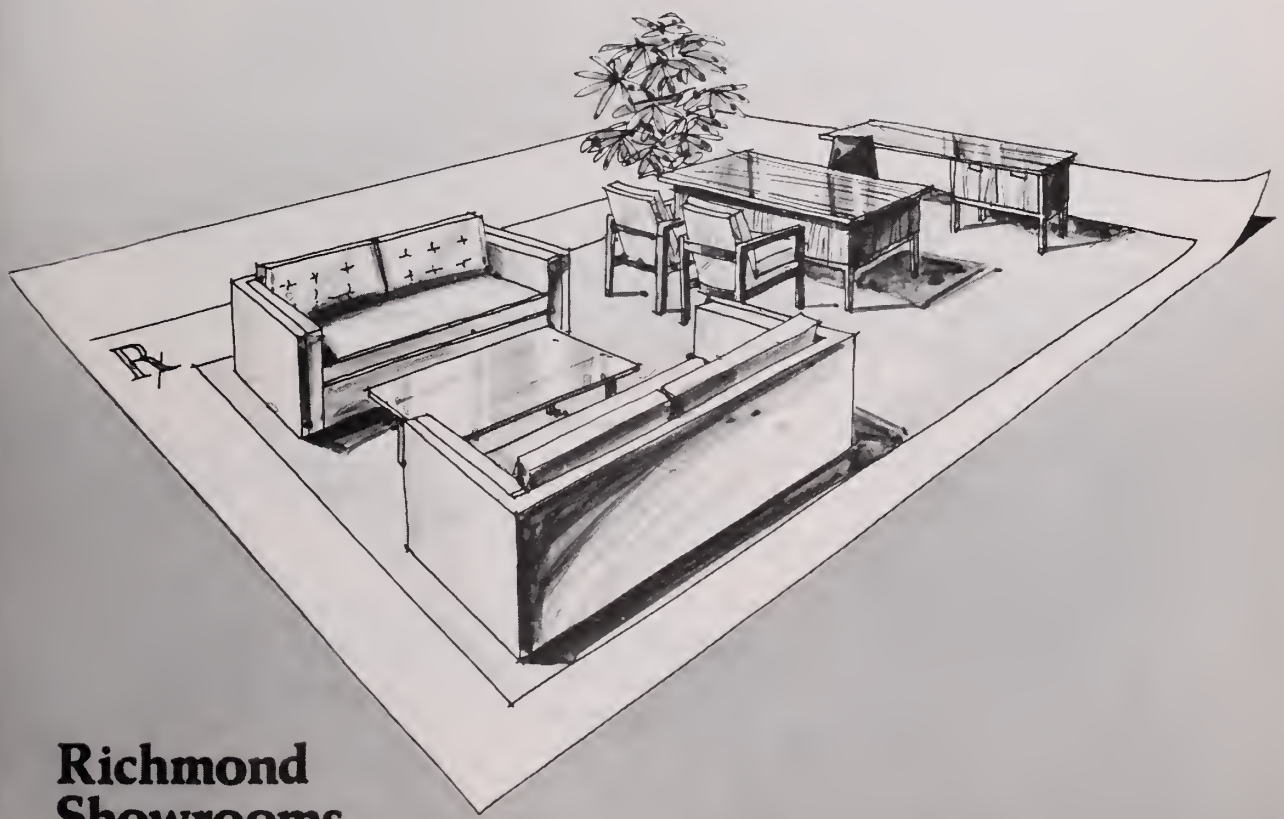


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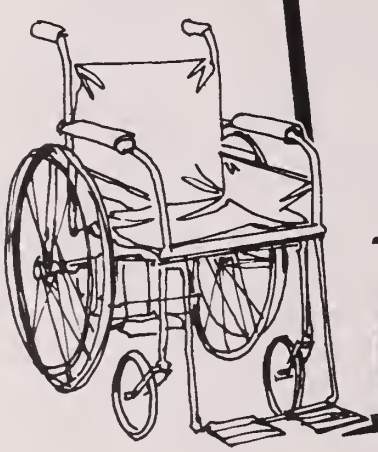
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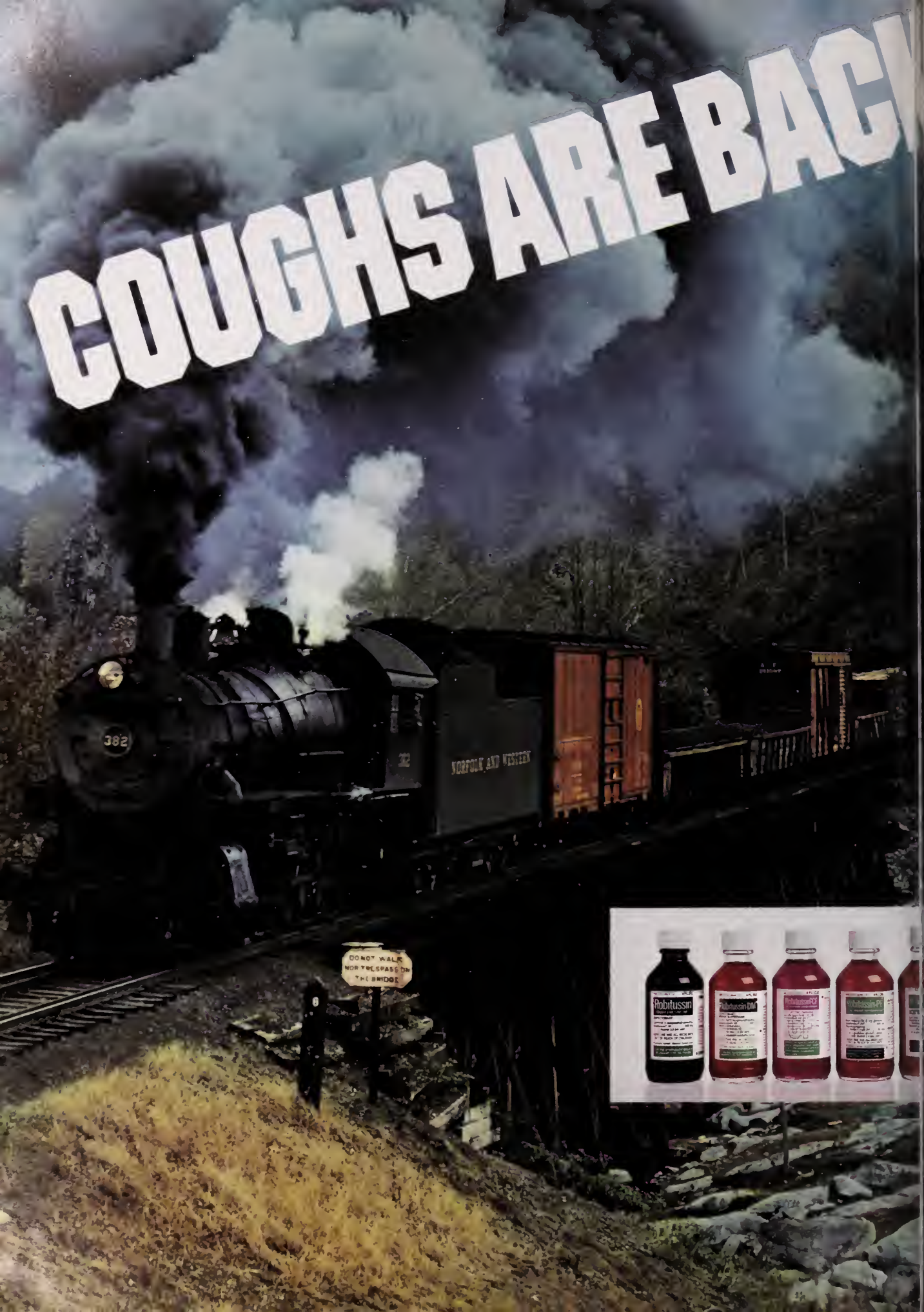
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Hyoscyamine sulfate	0.1037 mg.
Atropine sulfate	0.0194 mg.
Hyoscine hydrobromide	0.0065 mg.
Powdered opium, USP (equivalent to paregoric 6 ml.) (warning: may be habit forming)	24.0 mg.
Sodium benzoate (preservative)	60.0 mg.
Alcohol, 5%	

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PHOTO: Norfolk & Western Branch Train 202 west bound near Alvarado, Va (Oct., 1956). line reaches the highest point of any railroad of the Rockies (elevation 3,577 ft.) with a mum grade of 3%. It crosses 108 bridges, e 700 ft. long! Photo by O. Winston Link.

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For many years Robins has spotlighted the expectorant action of the Robitussin cough formulations by featuring action photographs of steam engines like the one on the preceding page. In keeping with this tradition, last year the company commissioned a well-known illustrator to render full-color drawings of several classic locomotives . . . accurate to the minutest detail. Chances are you requested and received the first locomotive in this series, The William Mason, last winter. Now, the second one is available. (See below). To order your print suitable for framing, write "Robitussin Clear-Tract Engine #2" on your Rx pad and mail to "Vintage Locomotives," Dept. T4, A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220.

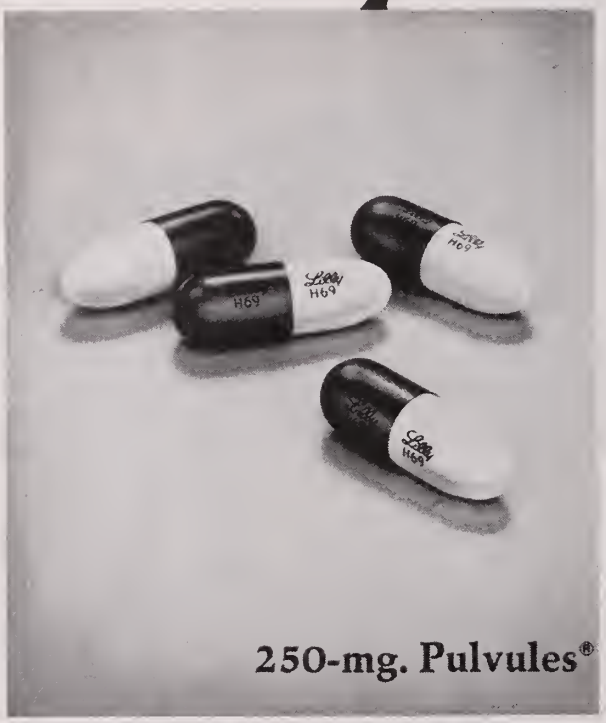


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VIRGINIA MEDICAL

ne 103 October, 1976 Number 10

Dr. Harry J. Warthen, this is your issue, dedicated to you in recognition and appreciation of your twenty years of faithful service as Editor of the VIRGINIA MEDICAL MONTHLY. The Germans have a word for an issue of this kind—*Festschrift,* a festival of writings both scientific and literary contributed admiringly to honor a colleague's scientific and literary attainments.

This journal was a young 81 years when you took charge as the seventh editor, guiding it past its 100th birthday. How splendidly you maintained and extended its vigorous maturity during your twenty years as Editor. Happily for all of us, as Emeritus Editor you have retained an active interest in the journal. Your wise counsel continues to be available, and

your literary style and knowledge of history and things Southern continue to grace these pages.

We are pleased to open this issue by reprinting on the page opposite an editorial of yours, one that shows your love of medicine and history, the great good humor of your writing and your geniality toward man and nature.

H. J. Thompson Jr.



HARRY J. WARTHEN, MD, EDITOR, AUTHOR, SURGEON.

Our Tree from the Island of Cos

Reprinted from the *Virginia Medical Monthly*, September, 1975.

SOME READERS of the *Virginia Medical Monthly* may recall that in June, 1973, the staff of The Medical Society of Virginia found a frightened little slip of a sycamore on the doorstep of our headquarters. It soon developed that this wisp of a tree was not an ordinary sycamore for it had a distinguished and undoubtedly longer pedigree than any living object in Richmond.

The story that accompanied the little waif explained that the seed that brought about this sapling came from the spreading plane tree reputedly beneath which Hippocrates (460-377 BC) taught the principles, the practice and the art of medicine. This venerable tree has begun to feel the sum of its years, for it has become necessary to support its weary limbs on marble columns that cluster about the massive trunk which measures 45 feet in circumference.

Our recent arrival is a close relative to our native sycamore but it is designated Plantanus orientalis whereas ours is called Plantanus occidentalis. In the Bible, it is simply referred to as the plane tree. Repeated efforts were made in the past to obtain offspring from the ancient tree, but for some reason unknown to the writer, the vast majority of seeds from the oriental variety are infertile. About ten years ago, a professor at the University of British Columbia discovered how to identify the fertile seeds, and his knowledge plus the enthusiasm of another professor in the same institution has resulted in the propagation of hundreds of saplings from the parent tree on the Island of Cos.

The Schering Corporation meanwhile undertook to give the various state societies and teaching centers the small trees as mementos of Hippocrates and this explains how we came by our little sycamore. When the writer first saw our sapling, it was potted in a Grecian vase of unusual design. The little tree measured less than 30 inches in height and contained nine leaves by actual count.

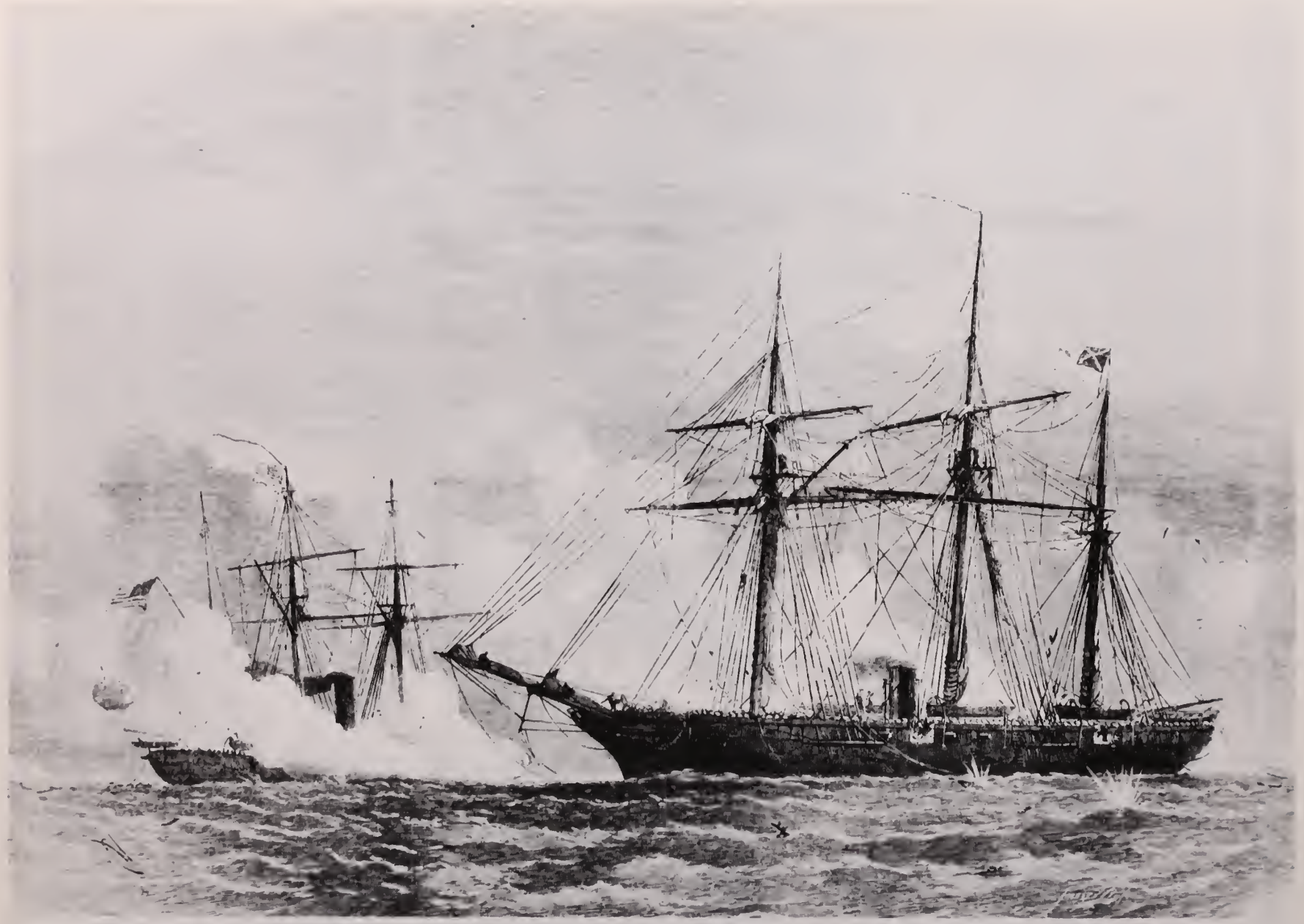
Fortunately, Schering sent detailed information regarding the care of these delicate imports. Special attention was given to the degree of protection required in various parts of this country. We found that Virginia is located in Zone 3, which permits our sycamore to grow in a "garden area". The chief warning was that our two-year-old would require indoor protection throughout the second summer to avoid possible heat prostration. This admonition now would be difficult to carry out, for less than two years after its initial planting, it now measures almost ten feet in height.

The accompanying photograph shows how fast an oriental plane tree will grow in Virginia. . . . In our article in the Journal two years ago, the hope was expressed that our little sycamore would like its new home, but now all misgivings are removed—it does like Virginia—and barring acts of Providence, we have every reason to believe it will follow in its pappy's footsteps and continue to shelter our headquarters until the year 4,500 A.D.



The tree and Dr. Tee. A drooping 18 inches on arrival, the "slip of a sycamore" has grown to a vigorous 18 feet.

H.J.W.



The famous fight between the CSS *Alabama* and the USS *Kearsarge* on June 19, 1864, off the coast of France, as conceived by an artist of the period. The *Alabama* was sunk in the engagement. Built to cruise the seas in search of Union merchant vessels, the *Alabama* had taken over 60 Northern ships with booty valued at 6 million

Doctor Spotswood and the Confederate Navy

W. R. Chitwood, MD, *Wytheville, Virginia*

"'. . . a brawny, gray-haired six-footer, rough and ready in ways and looks, but a gentle-hearted man,' was appointed Chief of the Bureau of Medicine and Surgery at the formation of the Confederate Navy . . ."

THE CONFEDERATE NAVY'S Bureau of Medicine and Surgery was a much smaller organization than the Medical Department of the Confederate Army, having only about 113 medical officers as compared to 3,237 in the army.[1-4] However, with its officers widely stationed on river gunboats, on cruisers on the high seas and in various naval hospitals, the Bureau needed an officer at its helm who was not only well trained in medicine but also had a special aptitude for administration. Such a combination was found in Dr. William Augustine Washington Spotswood, a Virginian by birth, who had been in the US Navy Medical Department from 1828 until he resigned to join the Confederate Navy in 1861.[5] Dr. Spotswood, described as "a brawny, gray-haired six-footer, rough and ready in ways and looks, but a gentle-hearted man,"[6] was appointed Chief of the Bureau of Medicine and Surgery at the formation of the Confederate Navy and served as its surgeon-in-chief until the end of the war. Historians have neglected this man, who undoubtedly excelled in the performance of naval medicine and efficiently headed his department during the Civil War.

W. A. W. Spotswood, born October 3, 1806, in Orange County, Virginia, was of the fifth generation directly descended from Virginia's colonial Governor Alexander Spotswood. Another Alexander Spotswood, a distinguished general in the Revolutionary War, was the grandfather of Dr. W. A. W. Spotswood; General Spotswood's wife was Elizabeth Washington, niece of George Washington. The father of W. A. W. Spotswood was George Washington Spotswood, and his mother was Lucy Spotswood (father and mother were cousins).[7] During the War of 1812, George W. Spotswood served as a lieutenant in an Orange County company of the Second Virginia Regiment[8]; after the war he remained in Orange County, where in later years he was known as Major Spotswood. (Today the family spells it "Spottswood.")

In 1825, when W. A. W. Spotswood was 19 years old, his father moved the family to Charlottesville, so that his sons might be educated at the newly established University of Virginia. Major Spotswood had a wife, six sons and two daughters to support, so he found it financially necessary to accept a position as one of the hotel-keepers at the university.[9] The hotels, as they were called, were part of the university buildings and were leased to prominent citizens, who were "expected to be men of discretion and firmness."[10] Besides boarding the students, the hotel-keepers furnished bedding, furniture, fuel and candles for the dormitories. Major Spotwood's building was Hotel F, situated at the southeast end of East Range; it was there his family lived from 1825 to 1829, except for a temporary removal to Pavilion I occasioned by an outbreak of typhoid.[10] Dr. Robley Dunglison, professor of medicine, attributed the epidemic to poor drainage in the buildings. None of the Spotswood family contracted the disease, but three of their servants died from it.

During his lease of the hotel Major Spotswood had many problems, for he had a volatile temper and often clashed with both students and faculty. At the same time, young Spotswood was meeting the challenges of obtaining a medical education. In addition to courses in anatomy, medicine, chemistry, medical

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jurisprudence, pharmacy and materia medica, he also studied ancient and modern languages. He was only a mediocre student, for Dr. Dunglison rated him tenth in his class of thirteen students.

In 1828, young Spotswood left the University of Virginia without receiving a medical degree, and, according to one of his biographers, went to Philadelphia for further study.[7] The records of the University of Pennsylvania Medical School and the Jefferson Medical Schools, the only two medical schools in Philadelphia at that time, do not reveal that he received a degree from either, but it is possible he attended classes. Regardless of a degree, he entered the medical profession with much more formal education than the majority of the physicians of that era. Apparently he had no difficulty in being commissioned an assistant surgeon in the United States Navy in December, 1828.[5]



Hotel F as it appears today on the University of Virginia grounds, Charlottesville. In this building at the southeast end of East Range Dr. Spotswood lived while studying at the University.

His first assignment was the USS *St. Louis,* Pacific Station, where he served until December, 1831. Following a leave of absence, he reported to Norfolk, Virginia, in 1832. There he soon encountered a severe epidemic of cholera, the first in North America, which had entered the continent at Quebec and New York from England and had spread rapidly. Before it was over, 400 persons had died from it in Norfolk alone.[11,12] Dr. Spotswood had never seen a case of cholera but gained much experience during this outbreak. He formed definite ideas about its treatment and in a journal he kept in later years discussed some of his conclusions. Like his colleagues, he was totally ignorant of the disease's pathology, but he learned that the patients treated by emetics and bleeding, as recommended by some of the distinguished physicians of the day, did poorly. Those whom he treated with opium, calomel, iced brandy and water did much better. Knowingly or not, Spotswood was reflecting the transition of American medicine away from the old regimens of Benjamin Rush (except for the calomel) to the more enlightened therapeutic principles of the French schools.

Spotswood was at Norfolk only a short time, and when he left for Pensacola, Florida, aboard the Sloop *Vandalia* he again encountered cholera.[5] Cholera broke out aboard the ship in the latitudes of Cuba; of the 14 cases, six persons were dead in five to six hours despite treatment. In addition to the medications used at Norfolk, he also applied "cups freely over the stomach and liver and along the whole of the spinal column which seemed to relieve the severe pain in the back. . ."

Dr. Spotswood was a medical officer at the Pensacola Naval Hospital and Navy Yard until 1835. From 1837 to 1841 he was aboard the USS *Concord,* USS *Constellation,* USS *Boston* and USS *Warren,* in that order. These ships were in the West Indies Station. In 1837, after nine years of service, he was promoted to passed assistant surgeon, a big step up in the old navy. The next year he was designated full surgeon. Returned to the Pensacola Navy Yard for duty in 1842, he married Mary Reese Eastin, daughter of Colonel Thomas Eastin of Mt. Vernon, Alabama. Eastin, a printer, publisher and member of General Andrew Jackson's staff during the Seminole War, had migrated to Alabama from Lexington, Kentucky, his birthplace. Mrs. Eastin was the former Lucinda Gayle of Charleston, South Carolina.[13]

Dr. Spotswood remained at Pensacola for three years; then he returned to sea duty, serving aboard several ships. During the Mexican War he was sent to the naval hospital at Salmidina, an island just off Vera Cruz. In 1857 he was made Fleet Surgeon of the East Indies Squadron, with his headquarters aboard the USS *Powhatan.* This fleet was composed of four steam frigates and three sloops.

In 1860 he returned to Pensacola, where he was surgeon when Florida and Alabama seceded on January 11, 1861. The next day the militia of these states took over the Pensacola Navy Yard, and Dr. Spotswood resigned his commission in the United States Navy a week later. Doubtless he did this with mixed emotions, for he had served under the Stars and Stripes for 33 years.[5] Yet, since his roots were in Virginia and he had served at Pensacola for so long that he considered Florida his home state, he offered his services to the Confederacy.

Because of his long experience and fine record, Dr. Spotswood was appointed Chief of the Bureau of Medicine and Surgery by Confederate Secretary of the Navy Stephen R. Mallory. Before he reported for

duty in Richmond, he decided to move his family, which now included his wife, six sons and a daughter, to a safer place. He decided on Monroeville, Alabama, about 100 miles northwest of Pensacola, and moved them there by wagon.

Facts about Spotswood's life in Richmond during the war and his administration of the Bureau are almost nonexistent. None of his personal letters have been found, and the records of the Confederate States Navy were destroyed at the close of the war when Richmond burned. The little information obtained was found mainly in the *Official Records of the Union and Confederate Navies of the War of the Rebellion,* 30 volumes and index, published by the US Government Printing Office after the war.

SPOTSWOOD'S DUTIES as chief medical officer were to procure medical supplies for the navy, supervise naval hospitals and medical officers and see to the health of the navy in general.[15] He was aided in the administration of these many duties by C. N. Fennell, chief clerk, and had an excellent medical purveyor in Robert Lecky, a chemist and apothecary,[16] who performed wonders in obtaining, manufacturing and distributing the medical supplies.

The hospitals for navy personnel were at Norfolk, Pensacola, Richmond, Charleston, Mobile, Savannah and Wilmington. There were also medical facilities at Selma, Alabama; St. Marks, Florida; Charlotte and Smithville, North Carolina; and Drewry's Bluff, Virginia.[4] Although supplying these hospitals was difficult, especially near the end of the war, they were evidently much better equipped and provided than their counterparts in the Confederate Army. As late as November, 1864, Dr. Spotswood in a report to Secretary Mallory stated that the purveyor's department was providing ample supplies of medicines and instruments and that the hospitals had clean, comfortable bedding, blankets and crockery.

Early in the war, medicines and surgical supplies were obtained from England via Bermuda for the Confederate hospitals[4]; but as the Federal blockade tightened, it was necessary to obtain medicines locally. Lecky was successful in meeting this demand by manufacturing a number of items at a lower cost than they could be purchased from the English supplier. Quinine was the one thing the purveyor had difficulty in procuring. As the shortage increased, its price rose to $100 an ounce;[17] and in the summer of 1863, when malaria was so prevalent in the Confederate Navy at Mobile, it was unobtainable at any price.[18]

Most of the smaller Confederate vessels were not stocked abundantly with medical supplies, as the injured and sick were sent to shore installations as soon as possible. To give an idea of what supplies were aboard them, an inventory made by Surgeon William F. Carrington on the CS Ram *Baltic,* a small, ironclad river boat, is presented[19]; it was made when the Baltic was in the Mobile area.

The food supplies for the Confederate naval hospitals were presumably the same as elsewhere in the South. Toward the latter part of the war, shortages increased. One captured Federal naval surgeon, describing conditions at the Savannah Naval Hospital, stated, ". . . while at Savannah, I tabled with the rebel surgeons in the hospital, and during all my stay there, nearly six weeks, we had coffee never, tea only

INVENTORY OF THE CS RAM BALTIC, JUNE 6, 1864

7 yds. bandages	1 oz. alum	3 oz. tinct. ginger
3 yds. lint	2 oz. soda borate	½ oz. aro. ammonia
2 boxes adhesive plaster	1 pd. cubebs (pulv.)	3 sticks caustic
1 case surgical instruments (small)	2 pd. flax seed	8 oz. blistering oint.
	¼ pd. sulph. precip.	½ oz. sod. potass.
2 spatulas	½ pd. simplex	4 oz. blue mass (n. hydrog.)
1 pair scissors	1 oz. quinine	½ oz. extract colocynth
4 tourniquets	1 pd. chloroform	½ oz. morphine sulphate
1 ball extractor	1 pd. spirits of nitre	8 oz. calomel
2 rolls white tape	2 oz. camphor	6 oz. laudanum (tinct.)
1 marble slab (white)	1 bottle alcohol	2 oz. wine of opium
1 pair scales & weights	4 bottles castor oil	1 drop measure
1 mortar and pestle	1 bottle olive oil	1 register
1½ pd. Castile soap	4 oz. magnesia (Cal.)	6 bottles whiskey
6 sponges (small)	7 oz. chloroform	8 oz. aug. hydrang.
3 pd. sulphate of magnesia	1 pd. copaiva (balsam)	2 oz. carb. ammonia
2 pen holders	4 oz. spirit lavendar	2 oz. opium
2 paper pens, 1 lead pencil	4 oz. tinct. colchicum	1 oz. tartar emetic
2 packages envelopes	4 oz. sulphuric acid	½ oz. olei tiglii
½ pd. ipecac	4 oz. rhubarb (pulv.)	4 oz. narcotic
¼ pd. linseed	½ pd. carbonate of soda	2 oz. iodide mercury
1 pd. mustard	4 oz. Dover's powders	½ quire writing paper
1¼ pd. acacia (pulv.)	2 oz. nit. silver crys.	1 journal
3 oz. potash bitartrate	1 oz. jalap	1 case amputating insts.

about five or six times, butter about as often; and to the credit of the surgeons be it said that while they denied themselves the luxuries of tea at $30 to $40 per pound, they had it furnished to our wounded and generally fed them better than they fed themselves."[20]

As for the diseases encountered by the Confederate naval surgeons, malaria was the principal one. Dr. Spotswood reported it as being particularly bad at Mobile in the summer of 1863[4]; another writer estimated that half of the seamen there were on the sick list.[21] Spotswood blamed the high incidence of malaria at Mobile on the fleet's anchorage in the marshes and suggested the ships be moved to a healthier place.

The personnel of the James River Squadron was also plagued by malaria; in 1864 it became so severe that Dr. Spotswood appointed a special committee of naval surgeons to investigate the sanitary conditions of that squadron. This group decided that the malaria was due to the "necessary consequence of a residence upon the waters of the James River," but that other conditions, such as the intense heat inside the ironclads, the lack of exercise on shore and the scant supply of vegetables and fruits, were also contributing to its cause. The committee concluded that the fleet should be moved to a place where the winds did not blow from the marshes. They knew nothing of mosquitos as a vector, but they were getting at the remedy indirectly. The only other recommendation of the surgeons was a ration of whiskey in the men's early morning coffee.[4]

The other infectious disease that was a major cause of illness in the Confederate Navy was yellow fever. The areas most affected by this contagion were Wilmington, North Carolina, and Charleston, South Carolina.[21 23] In the fall of 1862 both of these port cities were disastrously visited by this old enemy, killing many civilians as well as army and navy personnel. It was thought to have been brought in from Nassau by blockade-running steamers.[24]

Fatalities among the Confederate Navy medical officers were very few—three in all, two by drowning and one from natural causes. The fate of Dr. David Herbert Llewellyn, a young English doctor who was in the service of the Confederacy aboard the CS Steamer *Alabama* when it was sunk, has been told in several narratives. His bravery in staying with the wounded until the last minute and then drowning almost in sight of his native land was truly a deed of "self-sacrificing courage and devotion."[25-28]

The other medical officer killed in the Confederate naval service was Dr. Joseph Dana Grafton of the CS Cruiser *Florida,* who was tossed into a heavy surf from an upset shoreboat; he gave up an oar which was keeping him afloat to a seaman who could not swim.[29] Dr. Daniel S. Green, at one time fleet surgeon of the James River Squadron and a former surgeon in the US Navy, died of natural causes.[4]

Dr. Spotswood may have returned to Monroeville, Alabama, after the war, but during the 1870's, and possibly the 1880's, he was quarantine officer at Pensacola. In his last years he resided in Mobile, where he died on September 7, 1891, at the age of 84 years. His wife had died seven years before; both were buried in the Magnolia Cemetery at Mobile.[30]

The foregoing account is that of a dedicated naval surgeon and the medical organization he so aptly conducted. It does not reveal, however, that he was so unassuming that today no portrait of him can be found and that as a department head he ran his bureau so smoothly and quietly that his name never appeared in the newspapers of his day and his name is mentioned in Confederate Navy annals only in passing. It is hoped that these paragraphs will serve as a stimulus to bring to light more facts concerning this physician, who loved and served two countries and their navies.

Acknowledgements

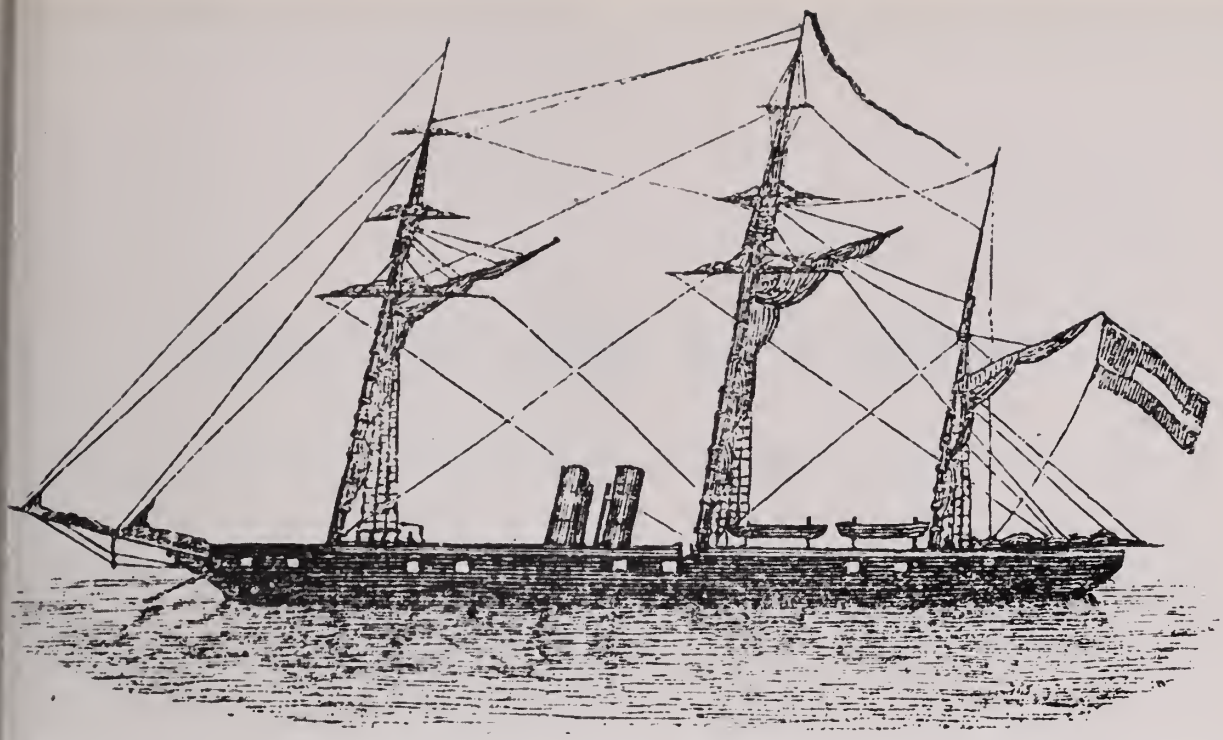
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he CS Cruiser *Florida,* a wiley sea raider and blockade runner, is shown above in a drawing that appeared in *Southern Punch* 1863. The *Florida* captured thirty-seven Northern ships and their treasure. Dr. Joseph Dana Grafton lost his life while serving as the Florida's surgeon. Courtesy of the Museum of the Confederacy.

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Anomolies of the Biliary Duct System

John R. Langley, MD, and Francis E. Rosato, MD, *Norfolk, Virginia*

The authors assess the surgical significance of biliary anomalies, especially concerning the ductal system, and present a case in illustration.

A HISTORY of vague bilateral lower thoracic pain, seven months in duration, was presented by E. C., a 60-year-old female. This pain was noted to be worse following ingestion of fatty foods. The patient also had noted symptoms suggestive of esophageal reflux and had had occasional nausea and vomiting. Her past medical history and physical examination were unremarkable. Laboratory data revealed hemoglobin of 11 gms%, hematocrit of 32%, white count of 4400 with normal differential. The remainder of her laboratory work was within normal limits. Chest x-ray revealed only the presence of cardiomegaly with no evidence of active disease, and her cardiogram was normal. Oral cholecystogram showed the presence of a single, large stone.

At elective cholecystectomy, an accessory right hepatic duct was found. This duct proceeded in a continuous fashion from the right lobe of the liver to the common duct at a point where it would usually receive the cystic duct. The remainder of the common hepatic duct, including the major right and left hepatic branches, appeared to be normal (Fig. 1). The gallbladder appeared to bud directly off this accessory duct without any true definable cystic duct being noted. Operative cholangiography was performed, and revealed no communication between the intrahepatic components of the normal biliary system with those of the accessory duct. For this reason, the gallbladder was amputated a short distance above its junction with the accessory duct. Postoperatively, there were no complications and the patient was discharged in routine fashion. Followup since that time has been uneventful.

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DISCUSSION

Authors of major anatomical textbooks and surgeons, speaking from their own experiences in biliary tract surgery, note the remarkable constancy of the extrahepatic biliary system. However, surgeons in particular are quick to warn others of the various anomalies that may occur in this region. Braasch[1], in a thorough review of biliary tract anomalies, points out that "the penalty for ignorance in this regard is high in terms of the frequent occurrence of biliary fistulas and common duct strictures". The exact incidence of major anomalies of the biliary duct system is not known; however, several major authors on the subject have reported these findings. Moosman and Coller[2], in a dissection of 250 cadavers, found accessory bile ducts in 40. Michels[3] found 36 accessory hepatic ducts in 200 autopsies. Goor and Ebert[4] found the incidence of accessory bile ducts and communicating biliary ducts to be between 14-28% in autopsy material. Murray, in a clinical investigation[5], reported only four cases of anomalous ducts in 309 cholecystectomies, in which cholangiograms were performed in virtually all cases. Flint[6] attempted in 1922 to classify accessory bile ducts by the level of their junction with the common hepatic duct. He

dentified three types: those joining the proximal half f the common hepatic duct; those joining the distal alf of the common hepatic duct; and those joining he common hepatic duct at the site where it would eceive the cystic duct. Braasch[1] made reference in a 958 article to nine common varieties of anomalies of he bile ducts and graphically depicted them. One articular pattern which he demonstrated appears to e similar to the case reported in this article.

A list of complications following biliary tract surery includes hemorrhage, biliary fistula, obstructive aundice and hepatic insufficiency. The majority of hese are iatrogenic in origin. Surgical dissection at holecystectomy may be complicated by the presence f major ductal and vascular anomalies and by other nrecognized variants of normal ducts and blood essels due to scarring and tissue retraction.

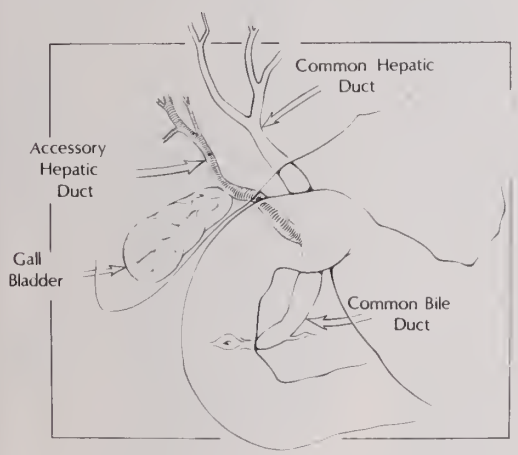
Moosman and Coller, after extensive dissection of 240 cadavers, defined a 30-mm area within the conines of the triangle of Calot (Fig. 2) containing the ollowing: 1. 85% of the accessory bile ducts found total 40); 2. 93% of the aberrant right hepatic arteries ound (total 47); 3. 83% of the normal right hepatic rteries; 4. 79% of the normal cystic arteries. The nrelenting need for total commitment to extreme are in dissection of this area is readily apparent from these figures. When confusion exists, operative cholangiography often provides critical information prior to taking definitive measures.

SUMMARY

A case presentation involving a major biliary anomaly, specifically an accessory right hepatic duct with absent cystic duct, is presented. A brief discussion of the literature follows on the major importance of biliary anomalies, especially concerning the ductal system. The surgeon is advised to keep an ever-present awareness of the frequency of these anomalies and the potential for harm to the patient should one of these structures be inadvertently divided or ligated.

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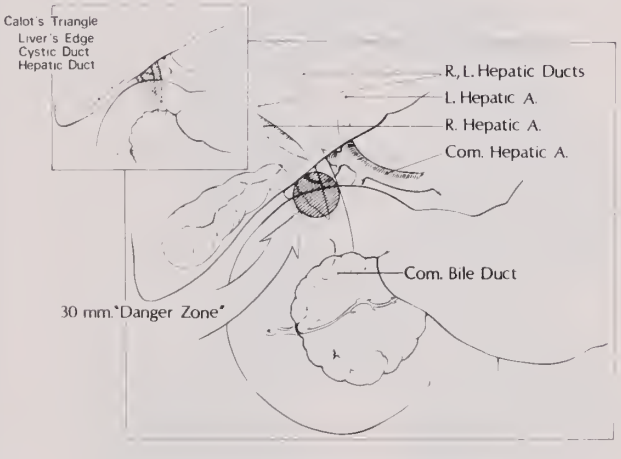


Fig. 1 (left). Line drawing made from operative cholangiogram. The gallbladder has been included for completeness.
Fig. 2 (right). The 30-mm "danger zone" within the triangle of Calot. Adapted from Moosman and Coller[2].

Sir Thomas Browne

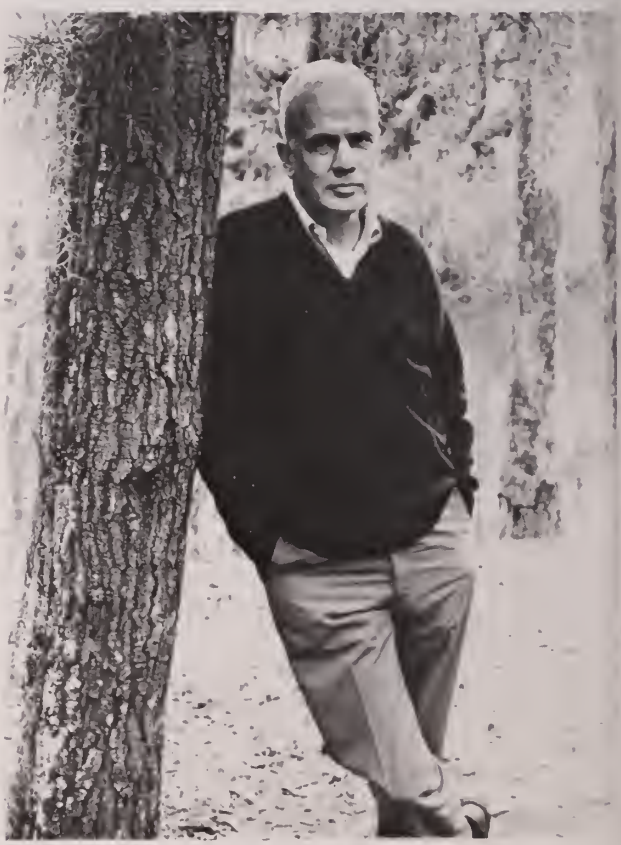


John Keats





Friedrich von Schiller



Walker Percy

Literary Doctors: Browne, Schiller, Keats, and Percy

David B. Adams, *Arlington, Virginia*

". . . What gives this group of men such significance is that their study of man did not end with the body; they used the soma as a starting point to explore man's spiritual life. Although this is a role now assumed to be that of the poet, it is not and has never been outside the realm of the physician . . ."

Vatibus et medicus unus Apollo favet.[1].

THE MYTHOLOGY of the Greeks, in which Apollo's favor was given to poet and physician alike, expresses a union of medicine and poetry which is easily overlooked today. Inasmuch as the percentage of physicians who are poets is small, this oversight is excuseable. Nevertheless, there is a select group of outstanding literary artists who were physicians as well. Anton Chekov, François Rabelais, Sir Robert Burton, Oliver Goldsmith, Tobias Smollet, Thomas Lodge, Oliver Wendell Holmes, Sir Arthur Conan Doyle, William Carlos Williams and Somerset Maugham—all trained as physicians and many of these men carried on full-time medical practices.

What is there in the experience of a physician which lends itself to the development of a poet or novelist? Somerset Maugham, British novelist and playwright, answers this question in explaining why he became a doctor. Describing his first hospital experiences Maugham writes:

> *Here I was in contact with what I most wanted, life in the raw. In those three years I must have witnessed pretty well every emotion of which man is capable. It appealed to my dramatic instinct. It excited the novelist in me . . . I saw how men died. I saw how they bore pain. I saw what hope looked like, fear and relief; I saw the dark lines that despair drew on a face; I saw courage and steadfastness. I saw faith shine in the eyes of those who trusted in what I could only think was an illusion, and I saw the gallantry that made a man greet the prognosis of death with an ironic joke because he was too proud to let those about him see the terror of his soul.*[2]

Maugham felt that all this was valuable experience. "I do not know a better training for a writer than to spend some years in the medical profession," he explained, for who "but the doctor sees human nature bare."

In addition to providing an opportunity to study man in times of crisis, medicine also provides the chance to study man in totality, that is, to study the psyche as well as the soma. And medicine is not just the study of man but of men; one has the chance to study others as one would study oneself. This is why Goethe studied medicine in Strasbourg and why Gertrude Stein went to Johns Hopkins. William Carlos Williams, an important 20th century American poet and a practicing pediatrician for fifty years, explained that Goethe and Gertrude Stein did not want to limit themselves to the abstractions but preferred the study of the whole and sought the somatic factor. "The practice of letters concerns the whole man no matter what the stylistic variants may be," Williams wrote.[2]

In order to look further into the question of what happens to the physician who becomes a poet or the poet who becomes a physician, it is worthwhile to look into the lives and works of a group of physicians who are best known for their contributions not to

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medicine but to literature: Sir Thomas Browne, Friedrich Schiller, John Keats and Walker Percy.

SIR THOMAS BROWNE (1605-1682) is the best known example in English literature of the physician as man of letters, the provincial doctor as philosopher and commentator on the universe and the mystery of life. By profession a physician, by nature a metaphysician, Browne was concerned with the intellectual and religious problems of the day: the seeming conflict between theology and science, the



Above, the Medical School of Padua, from an old print, and below, the University building, Leiden, from a drawing of about 1650. Both schools, were attended by Sir Thomas Browne.

questions relating to man's place, limitations and possibilities in the scheme of the universe.[3]

Born in London, Browne took his BA and MA at Oxford. He studied medicine in Montpellier, Padua and Leyden, where he took his degree of Doctor of Medicine. In 1637 he settled in Norwich, where for nearly half a century he practiced medicine and wrote his books. He was knighted by Charles II in 1671.

Browne's first and most popular work was the *Religio Medici*. Written when he was in his twenties, the *Religio* is an exposition of the beliefs of a young man who combined a devout religious temper with a skeptical and scientific turn of mind. Sir William Osler felt that the most precious book in his library was the *Religio*, and it was one of the first books he owned as a youth.

Hydriotaphia: Urn Burial was inspired by the discovery of an unusual number of ancient funeral urns in Walsingham. Browne, as the leading antiquary of the county, was asked to evaluate the urns. Instead of writing a discussion on the date of these urns, Browne used the incident to break into a noble prose poem and meditation on death. *Urn Burial* is believed to have no equal in the English language for solemnly beautiful diction and rhythmical prose. An exemplary passage in which Browne expounds on his belief that this world is "not an inn, but an hospital; and a place not to live, but to die in," follows:

> *The number of the dead long exceedth all that shall live. The night of time far surpasseth the day, and who knows when was the equinox? Every hour adds unto that current arithmetic which scarce stands one moment. And since death must be the Lucina of life, and even pagans could doubt, whether thus to live, were to die; since our longest sun sets at right descensions, and makes but winter arches, and therefore it cannot be long before we lie down in darkness, and have our light in ashes; since the brother of death haunts us daily with dying mementoes, and time that grows old in itself, bids us hope no long duration: diuturnity is a dream and folly of expectation.*[4]

Unlike some physicians who are led into an attitude of coarse cynicism through their constant encounter with suffering and death, Browne developed a skeptical attitude without its attendant coarseness. He was said to be incapable of thinking or writing anything vulgar. In harmony with the order of the world he lived in, Browne is an exponent of the genteel tradition of English literature.

The French critic Taine likened Browne to Shakespeare.[5] Taine found Browne to be the unusual observer who not only recognizes every single detail of that on which he is focused but is at the same time capable of recognizing the universal truths found in individual traits. The ability to stand aside and observe is a talent that is important to both physician and poet. When Browne looked at man, he saw a detached creature on the face of the earth, but looking beyond that view he saw into another world, the world of the poet.

Another theme which reappears with the poet-physician is his preoccupation with death and the transience of human life and mortal pleasures. This theme is well illustrated in the passage above from *Urn Burial*, and Taine concurs:

> *No one has spoken with a more elegant emotion of death, the vast night of forgetfulness, of the all-devouring pit of human vanity which tries to create an immortality out of ephemeral glory or sculptured stones.*[4]

But more importantly, Browne spoke not only of man's death but reached some kind of transcendence in speaking of man's spirit. "No one has revealed in

more glowing and original expressions the poetic sap which flows through all the minds of the age," Taine asserts.

FRIEDRICH VON SCHILLER (1759-1805) was an army surgeon before he became known as a poet, dramatist, philosopher, historian and with Goethe, who was his close friend, leader of the German Romantic movement. A lyric poet, Schiller wrote the "Ode to Joy" which Beethoven set to music in his ninth symphony. Schiller authored a significant history of the Thirty Years War, and wrote numerous dramas, including the popular *Wilhelm Tell.* He was also an important interpreter and developer of the ideas of Kant. It is interesting to note that the chief themes and ideas which Schiller explored in his poetic, dramatic, philosophical and historical writings were first developed in the treatise he wrote in requirement for his degree as Doctor of Medicine.

Schiller was sixteen years old and had completed one year of study of the law when he entered the Duke Karl Eugen's medical academy of Württenburg to begin preparation for a career as an army surgeon. He was a good student and won prizes in anatomy, practical medicine and surgery. His success may have been due to the fact that the predominant viewpoint in medical education then was that somatic disease was the result of a sick soul. Schiller's philosophical and poetic soul was receptive to the teaching of medicine through philosophy and for him medicine was not something practical but an abstract game of philosophical speculation. As he was nearing the completion of his degree requirements his closest friend died, and Schiller was overwhelmed by the crushing impression of death. "I am not yet 21 years old," Schiller wrote, "but am free to say that the world has no more charm for me."[1] He tried to gather himself together by reading Homer, Virgil and Shakespeare and by writing poetry and working on his drama *The Robbers.* Finally he overcame his grief while treating a depressed and suicidal young man in the Stuttgart hospital. This experience led to Schiller's treatise in 1780 "On the Relation between the Animal and Psychic Natures of Man." The treatise was a blending of materialistic and idealistic philosophy, the central thought being that mind and body greatly influence each other and that physical sensations set mental forces in motion and, conversely, that mental forces set in motion physical sensations.

Schiller postulated that the soul, protecting the body against harmful influences, is driven by the force of animal sensations which outweigh any elevated thoughts. "The most obstinate Stoic," explained Schiller, "exposed to the agonies of a calculus colic, will never be able to boast that he has not experienced any pain . . . The philosopher, who is explaining the nature of divinity and feels that he has broken through the bonds of mortality, is brought back to himself again by a cold north wind which whistles through his flimsy hood and is taught that he is the unhappy middle point between two worlds, beast and angel."[5] Schiller finds these physical sensations to be the foundations on which the soul has built civilization. He explains: "In the single individual animal impulses awaken the spiritual life, just as in the history of mankind, hunger, want and danger have been the most salient stimuli to the beginnings of culture." How "the mental moods followed the moods of the body" was another theme of the treatise. "All important diseases, but especially those called malignant, coming from the economy of the bowels, are accompanied by more or less of a revolutionary change in character."[6]


Die
Räuber.
Ein Schauspiel
von fünf Akten.
Herausgegeben
von
Friderich Schiller.
Zweite verbesserte Auflage.
bei Tobias Löffler.

Frontispiece of the 1782 edition of Schiller's *Die Räuber (The Robbers).*

Schiller's treatise was printed with the following dedication to his patron, the Duke Karl Eugen:

A doctor whose horizon is wholly bounded by the historical knowledge of his subject, who knows the coarser wheels of its most intricate clockwork merely as matters of terminology, can perhaps perform wonders at the bedside and be deified by the populace, but your Ducal Highness has raised the Hippocratic art from the narrow sphere of a mechanical livelihood to the higher level of a philosophical discipline. Philosophy and medicine stand side by side in complete harmony.

In 1780, seventy-five years before Virchow's theory of cellular pathology displaced the Greek humoral theory, it was a step upward to bring medicine to the level of philosophy and not a step down as is sometimes thought today, and Schiller's treatise was given unanimous approval.

Although Schiller showed far-reaching vision when viewing medicine from the high pedestal of philosophy, his observations on purely medical matters were poor. In a paper on inflammation and infection Schiller reveals next to no practical knowledge of the subject, omits most of the known facts and theories on infection and puts forth several false hypotheses of his own. Nevertheless, though Schiller failed to see the particular, his ability to generalize and theorize was excellent. This trait appears in the disagreement Schiller brought to the accepted definition of disease. As postulated by Sydenham, disease was the body's specific attempt to protect itself against a harmful agent. Believing that nature often acts without purpose against the well-being of the individual, Schiller felt that the organism often suffers more from the protective phenomena than from the harmful material itself; he suggested that disease may come only as a result of the reaction on the part of the organism. Disease should therefore be defined as the sum of the functional disturbances which are brought about by abnormal stimuli. The disease symptoms do not directly aim at the elimination of the harmful agent, but this elimination occurs only occasionally during the appearance of the symptoms. Schiller's understanding of disease would seem more likely to have been reached seventy five years after, and not before, Virchow.

When he became an army surgeon and medicine became a matter of human beings and not ideas, Schiller was inept. He soon found himself bored with the mechanics of practicing medicine in the confines of military practice (even though he undertook experiments on his patients). In 1781 *The Robbers* was published and immediately gained popular acclaim. For Schiller this was a calling back to the world of literature, and in 1782 when the Duke prohibited him from writing on any topics but those of medicine he fled the army medical service.

The influence of Schiller's medical experiences on his artistic work is widespread. The emotions which he experienced in his medical career are plainly apparent in his youthful poems. Paraphrases from his 1780 treatise are repeated in *The Robbers*. As a philosopher he based his ideas on the ethical ideal of noble humanity, his beliefs in freedom and his aesthetic theories on variations of the theme he first developed in the treatise. As a historian he showed how physical relations, climate and soil influence civilization and culture, the same theme present in the treatise. Indeed, Schiller's turning towards art and his pursuit of aesthetics was a logical consequence of his medical experience and his observation of suffering and death in the hospital. Schiller became a poet of the ideal only after completing training with the actuality of the diseases of nature and the death of human life.

JOHN KEATS (1759-1821), one of the most delightful and important of the English Romantic poets, spent as much of his brief life in the study of medicine as he did in the writing of poetry. Since Tennyson, hardly any English-speaking poet has been uninfluenced by the young genius who did not write any poetry till he was 21 years old and had completed his medical training.

The facts about John Keats's early life illustrate the truism that fortune often lavishes the gift of genius without regard for social circumstances.[3] His father worked in a livery stable and his mother was the daughter of an innkeeper. Keats's father died when the boy was nine years old, and six years later his mother was dead from tuberculosis. Fond of history, music and literature and fascinated by classical mythology, Keats was removed from school by his guardian shortly after his mother's death and was apprenticed to an apothecary-surgeon.

There were many rural parts in eighteenth century England where no university-educated physician practiced and medical care was provided by an apothecary-surgeon. With such an apothecary-surgeon Keats spent four years of apprenticeship, which was followed by a year of training at Guy's Hospital Medical School in London. Keats showed skill and knowledge in completing the course of medicine at Guy's, but he found himself temperamentally unfit for the practice of medicine. In a letter to a friend Keats wrote:

My last operation was the opening of a man's temporal artery. I did it with the utmost nicety, but reflecting what passed through my mind at the time, my dexterity seemed a miracle, and I never took up a lancet again.[6]

Keats's classroom behavior was described by his

oommate at Guy's:

He attended lectures and went through the usual routine, but he had no desire to excel in that pursuit. In a room, he was always at the window, peering into space, so that the window-seat was spoken of by his comrades as Keats's place . . . In the lecture room he seemed to sit apart and to be absorbed in something else, as if the subject suggested thoughts to him which were not practically connected with it. He was often in the subject and out of it in a dreamy way.[6]

His roommate explained further how Keats never placed much importance in his medical studies and looked upon medicine as a way to live in a workaday world. Nevertheless, Keats "had a consciousness of his own powers, and even of his own greatness, though it might never be recognized."

Poetry was to his mind the zenith of all his aspirations; the only thing worth the attention of a superior mind; so he thought all other pursuits were mean and tame. The greatest men in the world were the poets, and to rank among them was the chief object of his ambition.[6]

In July, 1816, before he had completed the usual course of study, Keats passed a difficult examination to obtain a certificate of qualification to practice medicine. He enrolled at Guy's as a dresser (a surgeon's assistant). Six months later, however, Leigh Hunt published one of Keats's sonnets, and he began seriously to consider abandoning medicine as a career. "I find that I cannot exist without poetry—without eternal poetry—half a day will not do—the whole of it," wrote Keats. Although he once felt that he could be of greater service to men by serving in the medical profession, he finally gave way to his ambition for a life of poetry. To his guardian, who thought his ward a fool for seeking to abandon a medical career, Keats said: "My mind is made up. I know that I possess abilities greater than most men and therefore I am determined to gain my living by exercising them!" The separation was complete. At the age of 21, Keats had left the world of sickness and surgery at Guy's Hospital for the world of poetry and the Leigh Hunt circle—men like Wordsworth, Shelley, Lamb and Hazlitt. Four years later Keats died in Rome from tuberculosis.

The four-year apprenticeship to an apothecary-surgeon and the one year of intensive study at Guy's were not without effect on Keats. The close contact with pain and death, the intense observation of nature's diseased and deformed, the horrors of surgery without anesthesia could not fail to leave their mark on Keats. As seen with Browne and Schiller, one of



The operating theater of Old St. Thomas' Hospital, London, where Keats received training. Built in 1821, it is said to be the only early 19th century operating theater in England to have escaped demolition or conversion.

the emotional obstacles in a young man's medical education is the problem of reconciliation with suffering and death. Keats overcame this difficulty through his vision of art and ideal beauty. In "Ode to a Nightingale" Keats suggests that the bird's song, a type of poetry, may lift men for a while out of a sad and transitory life and bring them for a moment under the spell of a beauty that was not born for death:

Fade far away, dissolve, and quite forget
What thou amongst the leaves hast never known,
The weariness, the fever, and the fret
Here, where men sit and hear each other groan;
Where palsy shakes a few, sad, last gray hairs,
Where youth grows pale, and spectre-thin, and dies;
Where but to think is to be full of sorrow
And leaden-eyed despairs,
Where Beauty cannot keep her lustrous eyes,
Or new love pine at them beyond to-morrow . . .

The stanza above could have been written while thinking of the suffering and dying patients, young and old, lying in hospital beds. Keats continues the poem with a longing plea for a death without pain, a death before youth and beauty have faded.

Darkly I listen; and, for many a time
I have been half in love with easeful Death,
Called him soft names in many a mused rhyme,
To take into the air my quiet breath;
Now more than ever seems it rich to die,
To cease upon the midnight with no pain,
While thou art pouring forth thy soul abroad
In such an ecstasy!

In his search among transient human joys and fading earthly beauties for something that endures, Keats chose to look outside the world of medicine.

WALKER PERCY (1916-) might not have become one of the most important living American novelists if he had not been infected with tuberculosis while serving his internship at Bellevue Hospital in New York City. Winner of the National Book Award for fiction in 1962 for *The Moviegoer,* Percy has written two other novels, *The Last Gentleman* and *Love in the Ruins,* which have given him not only popular success but acclaim and respect in literary and academic circles. Born into an old and aristocratic family in Birmingham, Alabama, Percy grew up in Greenville, Mississippi. He began the study of medicine at Columbia College of Physicians and Surgeons after graduating from the University of North Carolina in 1937. Percy did not particularly like medical school and still remembers with distaste the box of bones he had to study in anatomy. Ironically, he was fascinated with pathology, for it was not long before Percy, as an intern at Bellevue, was infected with tuberculosis. "The same scarlet tubercle bacillus I used to see lying crisscrossed like Chinese characters in the sputum and lymphoid tissue of the patients at Bellevue. Now I was one of them,"[7] Percy wrote.

Percy was then not only cut off from the career he had planned, he was also unable to join his contemporaries as they went off to fight in World War II. He moved into a boarding house in New York because he could not find a bed in a sanitorium and began to read—mostly Kierkegaard—and write. Although living with tubercle bacilli and Kierkegaard in a boarding house in New York City does not seem a fortuitous occurrence, for Percy it was a revelation. "TB liberated me," he claimed. His illness, the enforced absence from his family, the solitude—all seem to have brought out in him one of those religious personalities whom William James called the "twice born."

Instead of becoming a clinician and diagnostician of sick bodies, Percy began to express himself as a clinician and diagnostician of the soul. The protagonists in Percy's novels are autobiographical in this sense, for they all show the traits of a man who has been cut off from the expected and conventional order of things and have come to see themselves as strangers in this world. Even as a college student, the protagonist in *The Last Gentleman* saw that younger men around him were "very much with themselves, set, that is, for the next fifty years in the actuality of themselves and their own good names. They knew what they were, how things were and how things should be. As for the engineer, he didn't know . . . Why ain't I like them, easy and actual?"[8]

The inner struggle of being outsiders, of feeling themselves to be in the grip of a profound disorder, leads Percy's characters, as he himself was led, on a search to see what others can't see because they are well. Binx, a character in *The Moviegoer,* shows this quality:

. . . goofy as he was, he knew two things not many people know. He knew how to listen and he knew how to get at that most secret and aggrieved enterprise upon which almost everyone is embarked.[9]

Binx, a man who is training himself to look steadily at the most commonplace things in his path in order to be able to see into the dark, complains about Harry Stern, a dedicated biologist who is "no more aware of the mystery which surrounds him than a fish is aware of the water it swims in. He could do research for a thousand years and never have an inkling of it . . . I could not see what difference it made whether the pigs got kidney stones . . . compared to the mystery of those summer afternoons." Just as the clinician must closely observe the sick to discover their physical ailments, it is Percy's sick protagonists who closely observe those who are well, the easy and

ctual, to discover the mystery which surrounds their piritual ailments. "I'm not well," reflects the engi- eer, "and therefore it is fitting that I should sit still, ike an Englishman in his burrow, and see what can e seen."[9]

A theme that appears frequently in Percy's work is aised in a recent collection of his essays, *The Mes- age in the Bottle:* "Why do people often feel bad in ood environments and good in bad environ- nents?"[10] The question is also asked by a character in *The Moviegoer,* who says, "Have you noticed that nly in time of illness or disaster or death are people eal?" This theme, which grew from the union of a loctor's experience with the ideas of Kierkegaard, ppears in *The Last Gentleman* when the physician Sutter tells about a patient "who lived under the ecessity of being happy. He almost succeeded but did not quite. Since he did not, he became depressed. He became very unhappy that he was not happy. I put him in the terminal ward of the hospital, where he was surrounded by the dying. There he soon recovered his wits and became quite cheerful."

Love in the Ruins, described as a "not wholly serious apocalypse," is a satire and fantasy about a time when all doctors are either proctologists or psychiatrists. The hero of the novel, a physician-philosopher, is the inventor of a device, a stethoscope of the spirit, which can measure the activity of specific centers of the brain and can diagnose ailments of the soul. Reminding us how little medicine of the soul has changed since the time of Schiller, Percy's hero, Dr. Thomas More, finds most people to be suffering from an imbalance of bestialism and angelism, that same affliction which Schiller discussed in his 1780 treatise, "On the Relation between the Animal and Psychic Natures of Man."

AFTER LOOKING at Sir Thomas Browne, Friedrich Schiller, John Keats and Walker Percy, are there any conclusions which can be drawn about the poet-physician? What do these uncommon men have in common? The first point to be made is that all these men have the ability not only to observe the actual but also to look beyond the ordinary and see what others cannot see. This ability to observe and to penetrate into everyday events and discover the mystery of living things is seen in particular with Sir Thomas Browne and Walker Percy. Another important theme noted is the preoccupation with death and the transience of life, especially in the work of Browne and Keats. In the case of Keats, the problem of life's transience was channeled into a search for eternal beauty. For Schiller, a serious exploration of aesthetics was undertaken in order to find meaning in the life of man.

Perhaps the most important aspect of these men's lives is their exploration of the world of man's spirit. In the world of medicine it is easy to become preoccupied with what Schiller would call bestialism, that is, the somatic factor, and overlook what Percy calls angelism, the spiritual factor. What gives this group of men such significance is that their study of man did not end with the body; they used the soma as a starting point to explore man's spiritual life.

Although this is a role now assumed to be that of the poet, it is not and has never been outside the realm of the physician. Returning again to Greek mythology, it is seen that the caduceus carried by Hermes, the son of Apllo, symbolizes Hermes's role as an intermediary between the land of the dead and the land of the gods. The serpent of the caduceus symbolizes Hermes's ties to the underworld and the wings above the serpent symbolize the elevating powers which lead to communication with the gods.[11] The physician, who has adopted the caduceus as his symbol, should understand that he is close not only to the land of the dead, but that he is also close to man's spiritual world. He should attempt to explore that sublime world as these poet-physicians did.

Acknowledgment

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Combined Bronchoscopy

William S. Hotchkiss, Sr., MD, and Juan M. Montero, II, MD, *Norfolk, Virginia*

The old and the new in bronchoscopic instruments is described, and a method for utilizing the advantages of each is advocated.

IT IS GENERALLY AGREED that the introduction of the flexible fiberoptic bronchoscope by Ikeda in 1968[1] constitutes one of the significant advances in the diagnosis and management of pulmonary disease. It has become incumbent on every thoracic surgeon (and other endoscopist) to familiarize himself with this advanced instrument and to develop his technical skill in its manipulation and utilization.

It is not the purpose of this paper to describe the many varied techniques for diagnosis which are available with this versatile instrument. Suffice it to say that with its narrow outside diameter (5.4 mm)[2] and its controlled flexible tip, it is possible to introduce it into many distal bronchial branches which are not accessible to the conventional straight metal bronchoscope.[3]

Along with these advantages, however, this instrument has certain limitations, and occasionally its capacity is exceeded by the old straight Jackson bronchoscope.

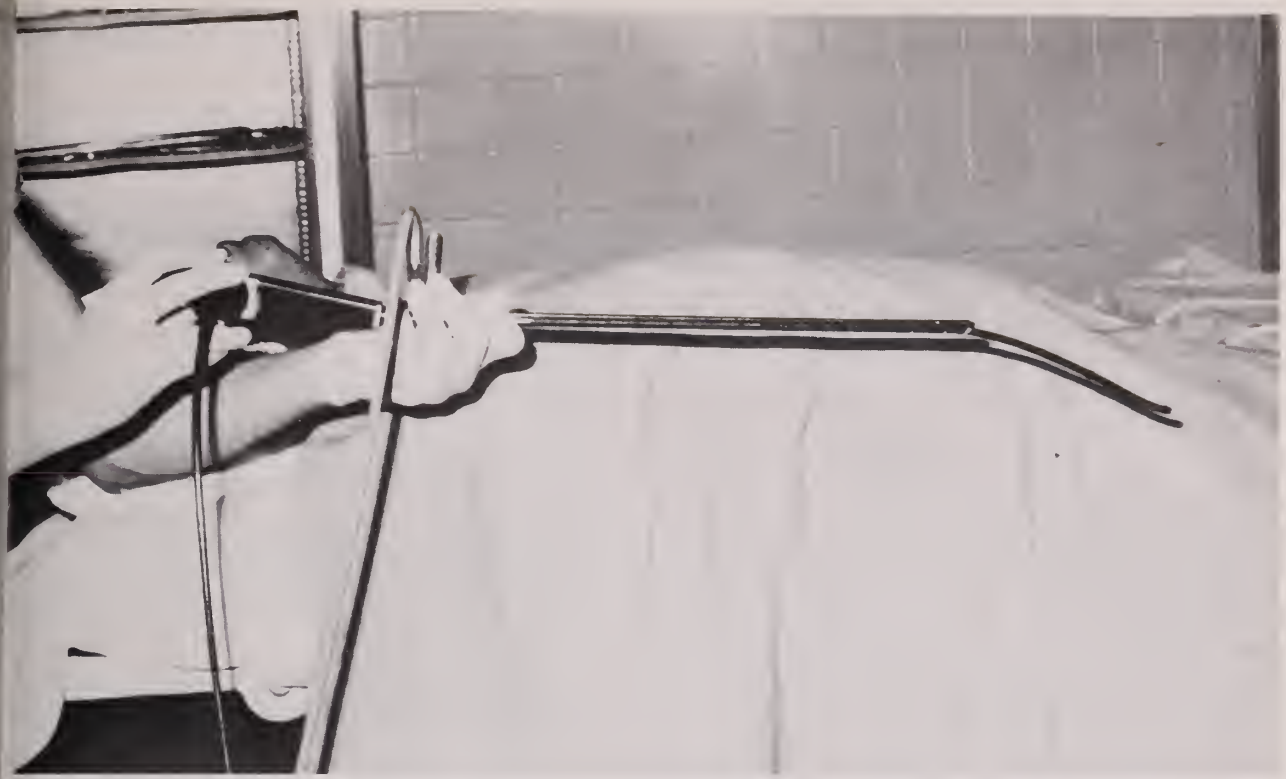
- It is almost impossible to deal with foreign bodies or aspirated material through the fiberoptic bronchoscope.
- Abundant thick secretions are difficult to remove through the small inner lumen of the flexible bronchoscope.
- Biopsies are quite possible with the flexible scope, but a larger specimen can often be taken more easily with the conventional bronchoscope.
- In the presence of active bleeding, especially when mixed with thick secretions, it is sometimes impossible to clear the field adequately for good visualization with the small flexible bronchoscope.

Address communications to Dr. Hotchkiss at 702 Medical Tower, Norfolk VA 23507.

Submitted 10-27-75.

In view of the above it is difficult to convince the older thoracic surgeon and bronchoscopist that he should discard the straight bronchoscope which has served him so well over the years.[4-6] Therefore, the writers have evolved a technique of combined bronchoscopy with both instruments which can be described as follows. Topical anesthesia is obtained with any preferred agent. Following this, an 8×40 full lumen bronchoscope is passed and all of the usual observations made of the bronchial tree visible with this instrument. If this is done in an orderly manner and with a little experience, the standard diagnostic examination can be carried out in three minutes or less. This, of course, does not include the management of foreign bodies, collection of biopsy material or right angle telescopic visualization of the upper lobes. Foreign body and biopsy work can be done much more efficiently with the standard instrument; and when combined bronchoscopic study is planned, using both instruments, telescopic visualization of the upper lobes is not carried out.

After this portion of the procedure has been completed and all thick mucoid material and blood, if any, has been removed with the aspirating suction tip, the Jackson bronchoscope is withdrawn to a point just above the carina. At this point the flexible Olympus bronchoscope is introduced directly through the Jackson bronchoscope, and further examination of the upper lobe bronchial segments, the middle lobe and the distal portions of the basilar segments is carried out, with biopsy or brush if in-



Demonstration of available length of flexible bronchoscope beyond tip of Jackson bronchoscope.



Flexible fiberoptic bronchoscope being introduced through 8×40 Jackson bronchoscope.

dicated in these areas. If brushing is carried out, it is helpful to have the Jackson bronchoscope in place so that the flexible instrument can be withdrawn and reintroduced with facility and without prolonging the procedure for the patient. After the examination has been completed with the flexible scope, washings are collected either through it or through the Jackson scope with the suction tip. Positive cytologic diagnosis is obtained in a statistically significantly greater percentage of patients after instrumentation has taken place. The instruments are then withdrawn at the conclusion of the examination.

The question of adequate ventilation always arises in a discussion of this technique. It has presented no problem whatsoever in our experience. An 8-mm Jackson bronchoscope will tolerate the 5.4-mm Olympus scope with ample room on the side for ventilation. No patients have ever had any trouble with this problem.

If bronchography is indicated, a catheter can be passed into the trachea before the Jackson bronchoscope is withdrawn and the patient transported directly to the x-ray department.

The medical profession needs to recognize that while the flexible bronchoscope is certainly a very remarkable instrument and adds a new and valuable dimension to diagnostic procedures in the bronchial tree, it does not by any means render the straight Jackson bronchoscope obsolete. Each instrument has advantages and disadvantages, and it seems only logical to combine the use of both instruments in a single procedure, if this can be done with facility.

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Nutritional and Surgical Management of Intestinal Fistulas

Neil E. Hutcher, MD, and Harold Levinson, MD, *Richmond, Virginia*

A series of 50 patients with 61 gastrointestinal fistulas is reviewed. Adherence to established surgical principles plus maximum nutritional support resulted in 92% successful fistula closure. Diagnostic and therapeutic measures are emphasized.

THE TREATMENT of gastrointestinal fistulas presents a complex and challenging problem, for it is associated with a high rate of morbidity and mortality due to the secondary problem of sepsis, fluid and electrolyte imbalance, skin erosion and malnutrition. Early reports indicated mortality rates in the 40-65% range.[1,2] Edmonds et al[3] and Sheldon et al[4] were among the earliest to demonstrate a significant reduction in mortality in those patients who were able to receive 1500 to 3000 calories/day. Unfortunately, only a limited number of patients were able at that time to ingest and absorb that amount of calories. The advent of parenteral hyperalimentation in 1968,[5] and elemental oral diets[6] made it possible to nourish adequately all fistula patients. MacFayden, Dudrick and Ruberg,[7] applying the basic principles of fistula management plus adequate nutrition in all patients, were able to effect successful closure of 94% of fistulas with a mortality of 6.4%.

This dramatic improvement prompted us to review the most recent group of fistula patients at the Medical College of Virginia.

MATERIALS AND METHODS

Fifty patients with 61 intestinal fistulas were treated on the surgical service during the period January 1972 thourgh November 1975. There were 35 males and 15 females with a mean age of 42.6 years (newborn to 81 years). The mean duration of fistula drainage was 52.5 days with a hospital stay of 67.7 days. Intraoperative technical problems and/or postoperative infection played a major role in development of the fistula in 47 patients. Other contributing factors in the formation of fistulas were intestinal obstruction, inflammatory bowel disease, cancer and ischemia. Forty-one patients had undergone a total of 74 operations prior to developing fistulas. Twenty-four patients underwent 26 surgical procedures after development of fistulas.

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Presented at the annual meeting of the Virginia Surgical Society, Hot Springs, Virginia, April 30, 1976.

TABLE I

INITIAL DIAGNOSIS

Inflammatory bowel disease	11
Gunshot wound, abdomen	6
Carcinoma (stomach, esophagus, colon)	6
Appendicitis	5
Multiple trauma	4
Intestinal obstruction	3
Duodenal ulcer	3
Miscellaneous	12

Table I lists the initial diagnosis of the illness leading to fistula formation. The two leading diagnoses were inflammatory bowel disease and trauma.

Therapeutic principles included adequate surgical drainage; accurate fluid and electrolyte balance; aggressive diagnostic maneuvers to demonstrate intestinal continuity and absence of obstruction distal

to a fistula: appropriate and judicious use of specific antibiotics; early surgical intervention as indicated; early closure of all wounds; protection of surrounding skin; maximum nutritional support.

RESULTS

Table II lists the location of each fistula and the closure rate of nutritional therapy (spontaneous), nutritional therapy plus surgical correction of the fistula (combined), primary surgical closure (primary), and treatment failures. The results expressed in patients rather than fistula response revealed 54% healed spontaneously with nutritional support in a mean of 43.3 days. Nutritional support combined with surgical closure was successful in an additional 16% with a mean closure time of 63 days. Fourteen percent underwent successful primary surgical closure. Sixteen percent failed to close regardless of therapy. The overall mortality was 16%.

Parenteral or a combination of parenteral and elemental enteral hyperalimentation was used in 28 patients for a period of 64 and 50.9 days respectively. Eight additional patients received enteral hyperalimentation for 27.6 days. Each of these methods provided 2633 to 3587 calories/day. Special attention was afforded to sterility during catheter placement and later care of the catheter. Intravenous hyperalimentation was given for 1856 patient days with an average of 1.44 catheters/patient. There were five septic episodes (three bacterial, two fungal) related to hyperalimentation or 1/371.2 patient days. Significant amounts of exogenous insulin were required in 24.4% of the patients. Hyperosmolar coma, dehydration and acidoses were not problems. Patients not receiving special nutritional support either had been admitted for primary closure of a preexisting fistula or had distally located low-output fistulas.

DISCUSSION

Although much emphasis has been placed on nutritional support, this is but one facet in the management of this complex problem. The use of suction drainage and sterile ostomy bags in and about the fistula wound greatly facilitates drainage of the wound, accurate fluid and electrolyte therapy, and skin care. Large open wounds are often associated with fistulas. When these wounds have granulated they should be promptly closed or grafted. This can be done in the operating room or at the bedside with the portable dermatome and local anesthesia. In several instances the use of a topical antibacterial agent such as silvasulfadiazine (Silvadine®) or a biologic dressing of porcine skin have been helpful in reducing bacterial content of a wound and preparing it for early autografting.

Sepsis remains the leading cause of death in these patients; of eight deaths in our study, six were due to sepsis, two of these with inflammatory bowel disease. Two patients died of terminal cancer.

A high index of suspicion, frequent examinations and liberal use of fistulagrams and scans should be used to detect abscesses. Adequate surgical drainage, usually with suction devices, should be carried out promptly. Culture specific antibiotics should be used when indicated. Since anaerobic organisms are present in 80% of intraabdominal infections and are difficult to grow in all but the most sophisticated laboratories,[8] antibiotic coverage for these organisms should be included. The patient's general immunologic resistance must be maintained. Adequate nutrition, the avoidance of steroids (inflammatory bowel disease) and limitation of broad spectrum antibiotics are important in this respect.

There was no specific time limit after which failure of the fistula to close spontaneously was inevitable. Aguirre, Fisher, and Welch[9] have stressed the importance of establishing that the fistula is not associated with total lack of bowel continuity or distal obstruction. Such a fistula will not close spontaneously and early surgery is recommended. The barium meal and/or enema in combination with a fistulogram em-

TABLE II

TYPE OF FISTULA AND RESULTS BY LOCATION

	Spontaneous	Combined	Primary	Failed
Gastrocutaneous	1	1	0	0
Duodenocutaneous	3	2	0	0
Enterocutaneous	21	3	5	4
Colocutaneous	4	2	3	2
Pancreaticobiliary cutaneous	3	2	0	0
Internal	2	1	0	2
Total	34	11	8	8
Percent	55.9%	18%	13.1%	13.1%

TABLE III

REASON FOR FAILURE TO SPONTANEOUSLY CLOSE

Mechanical	5
Infection	7
Inflammatory bowel disease	4
Cancer	2
Unknown	2

ploying water soluble contrast media facilitates this differential. Table III lists the reasons for failure of spontaneous closure in our patients. It is our feeling that if a patient is improving as monitored by weight gain, progressive wound healing and freedom from sepsis and if no distal obstruction or lack of intestinal continuity has been established, one should wait at least six weeks before contemplating surgical intervention.

Prior to the advent of current methods of hyperalimentation, a high-output fistula (greater than 200cc/day) was associated with increased morbidity and mortality, compared to lower-output fistulas[3,4] In our series 76% of fistulas were high-output. Neither morbidity nor mortality was associated with fistula output. This has been confirmed in other recent series.[7,9]

Of the eight patients who ultimately died, three died with their fistula closed. Four of the surviving patients were discharged with their fistula draining insignificant amounts; these later healed at home. Therefore, of the entire series 92% had eventual closure of their fistulas.

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Apologia

In the August issue report of the candidacy for MSV president of **Dr. Charles E. Davis, Jr.,** *Norfolk,* the list of his offices should have included his past presidency of the Medical Alumni of the University of Virginia. Additionally, the report should have made clear that Dr. Davis is a past president of the Virginia Surgical Society and was formerly Chief of Surgery, Norfolk General Hospital, and formerly Director of the Department of Surgery, DePaul Hospital, Norfolk. The staff very much regrets these omissions.

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In this House in Big Stone Gap, Virginia, lived John Fox, Jr., author of the famous *Trail of the Lonesome Pine*.



This huge transloader, where endless coal cars are loaded from the towering silos, is in Appalachia, Virginia.

Photographs by Melissa Strong

A Land Apart in the Old Dominion

Mrs. L. C. Strong, Jr., *Norton, Virginia*

". . . Out where the mountains of Virginia rub shoulders with those of Kentucky and West Virginia and nudge at the lake country of Tennessee . . ."

WHAT IS SOUTHWEST VIRGINIA? That is easy, says a Richmonder; it is Roanoke! But there are two hundred miles of Virginia beyond Roanoke. Out where the mountains of Virginia rub shoulders with those of Kentucky and West Virginia and nudge at the lake country of Tennessee. Where Bluefield is in both West Virginia and Virginia. Where State Street in Bristol is divided down its center by the Tennessee boundary. Where a compass centered at Norton draws a circle enclosing Richmond but also reaching Canada!

Southwest Virginia is mountain country, desolate in winter to an outsider, for then it is brown and black ink sketches, with bare-branched trees, hills scarred by strip mining, unpainted houses perched on hillsides in the stretches between towns. But as spring approaches the sarvis trees bloom with puffs of white, and the Judas trees, known elsewhere as redbud, blossom in lavender and fuchia shades. (Here the people tell that Judas was hanged on such a tree, and in its shame the tree has never since grown strong and mighty.) Next the multitudes of dogwood, white and pink, paint the mountains with color, mingled with the many greens of the deciduous trees. When autumn comes, the trees are alive with brilliant fall foliage, and visitors travel the narrow winding roads behind coal trucks and school buses to "see the colors."

In Wise County, almost the last county in the state before one crosses into Kentucky, one might want to spend a vacation. In the town of Appalachia is a huge transloader, where endless coal cars are loaded from the towering silos. Coal of many kinds has been trucked in, mixed, and stored in the silos until the string of empty cars rolls in.

Passing on to Big Stone Gap, one passes Bee Rock Tunnel, until recently renowned as the shortest tunnel in the country. Now the *Guinness Book of World Records* says the title has been lost—by three feet! Or one can drive the valley road from Norton to Big Stone, with a stop for the wonderful view of Powell Valley, a rolling green pastoral surrounded by the rocky hunched peaks where the ginseng hunters search for "seng."

It was in Big Stone that John Fox wrote his famous novel, *The Trail of the Lonesome Pine,* and here a visit would revolve around the trail itself. Then there would be a visit to John Fox's home, just as the family left it, replete with pictures and books, brushes and combs on dressers. The local historical group serves dinners here to make the money to put a new roof on the house.

On to the house where the book's heroine, June Tolliver, boarded when she came down from the mountains to go to school. For the book is based on reality—the engineer who came into the area looking for the minerals that would be the basis of a great steel industry was Jack Hale; the little girl of the mountains for whose education Jack Hale paid was June Morris; and "Devil" John Wright, who lived near Jenkins, Kentucky, was the model for the book's most famous character, "Devil" Judd Tolliver.

Volunteers will show you through the June Tolliver House, furnished much as it was when the girl lived there, and tell you the story. On the first floor one may stop to purchase crafts and books of the area. Beside the house the outdoor drama of *The Trail* plays, and here one sees the scenery standing outside the year round. The play itself was written by a group

Mrs. Strong is president of the Auxiliary to the Wise County Medical Society and treasurer of the Auxiliary to The Medical Society of Virginia.

of townspeople; it was a great success and now is given five days a week through the summer months.

Everywhere in the area coal is king, deep mine and surface. Coal by truck and coal by train. Until recently coke ovens glowed at night like giant candles to burn off impurities. Now, of the 4400 ovens built early in this century, few remain, and they are inactive, some destroyed by man and others surrendered to nature. Up Big Tom's Creek a solid mile of such ovens is nearly camouflaged by the growth of trees, bushes and weeds.

The other cash crop of the region is apples: double red Romes, winesaps, and the golden delicious, which make the very best heads for applehead dolls. For this is a land of native crafts. It is easy to find spinners, weavers, vegetable dyers, and shuck doll makers in addition to quilters and basketmakers. These are people who have learned from parents and grandparents the ways of their crafts.

Norton, the only city in Wise County, probably was named for Eckstein Norton, an official of the Louisville & Nashville Railway in the late 1880's. By law, a populated area in Virginia must have 5,000 residents to be called a city; in the 1970 census Norton dropped below this minimum, but a constitutional amendment was enacted with a "grandfather" clause allowing Norton to retain its city status. Norton is a medical center for the county. There are three hospitals in Norton, one in Wise, and another in Big Stone Gap.

Up the mountain in the town of Wise is The Inn. It is furnished with antiques, including chandeliers in the main dining room that were blown of glass in Venice 200 years ago.

And on toward the Kentucky border one comes to the community the road map says is Pound; but it's "The Pound" to its inhabitants and was so named, they say, because the first mill on the river was a horse-operated mortar and pestle which pounded the grain into meal. Here in the mountains are people of extreme independence, descendants of people who cherished the ability to do for themselves. These traits linger on, breeding qualities of friendliness and helpfulness. Isolated by the mountains in all their grandness, the people of this region stand together as their mountains do.

Statistics say there is one doctor for every 1,000 residents in this region. The wives and widows of doctors join in the auxiliary to foster health education and paramedical scholarships; many volunteer their services in hearing and cancer detection clinics.

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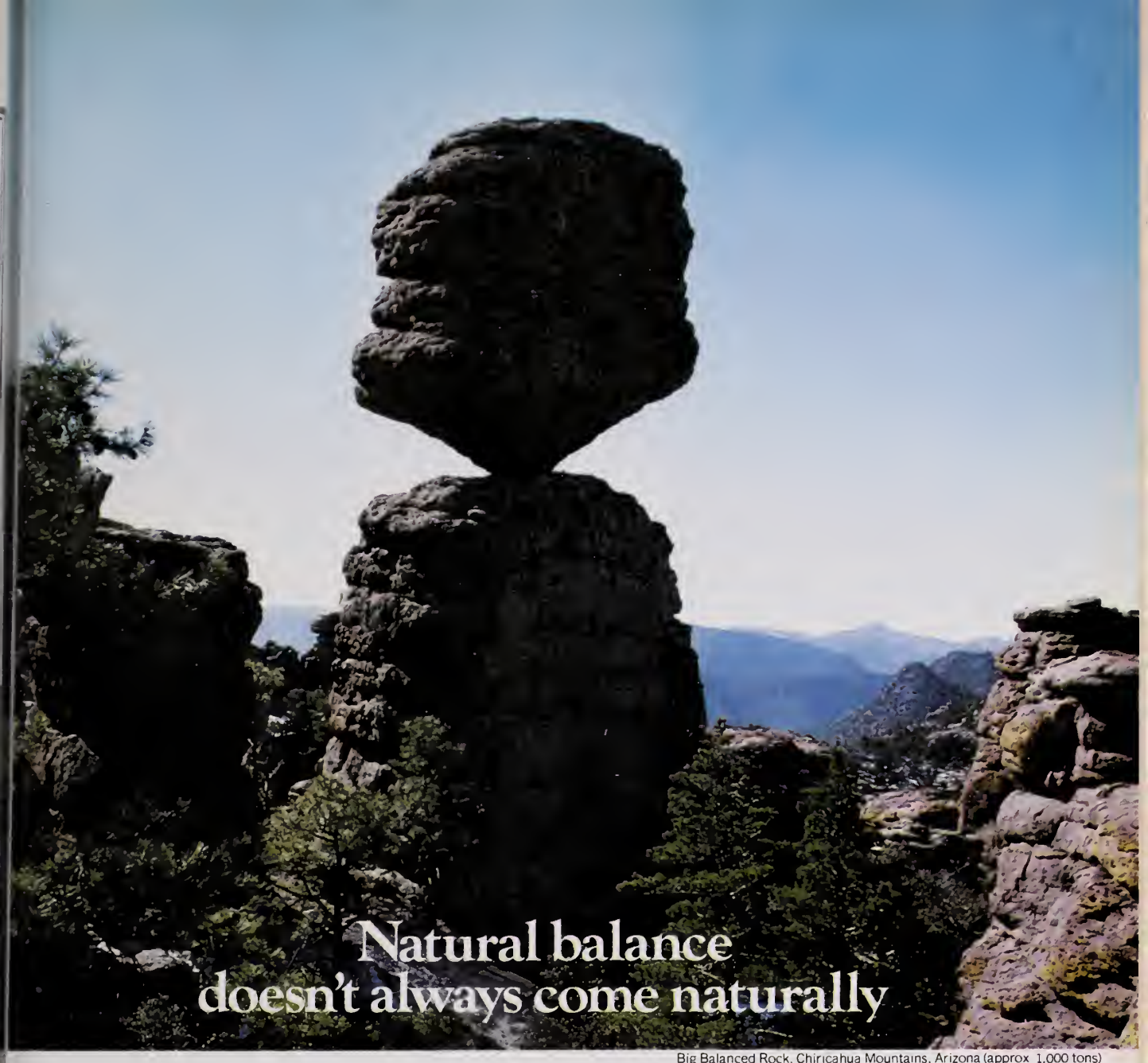
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Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

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Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

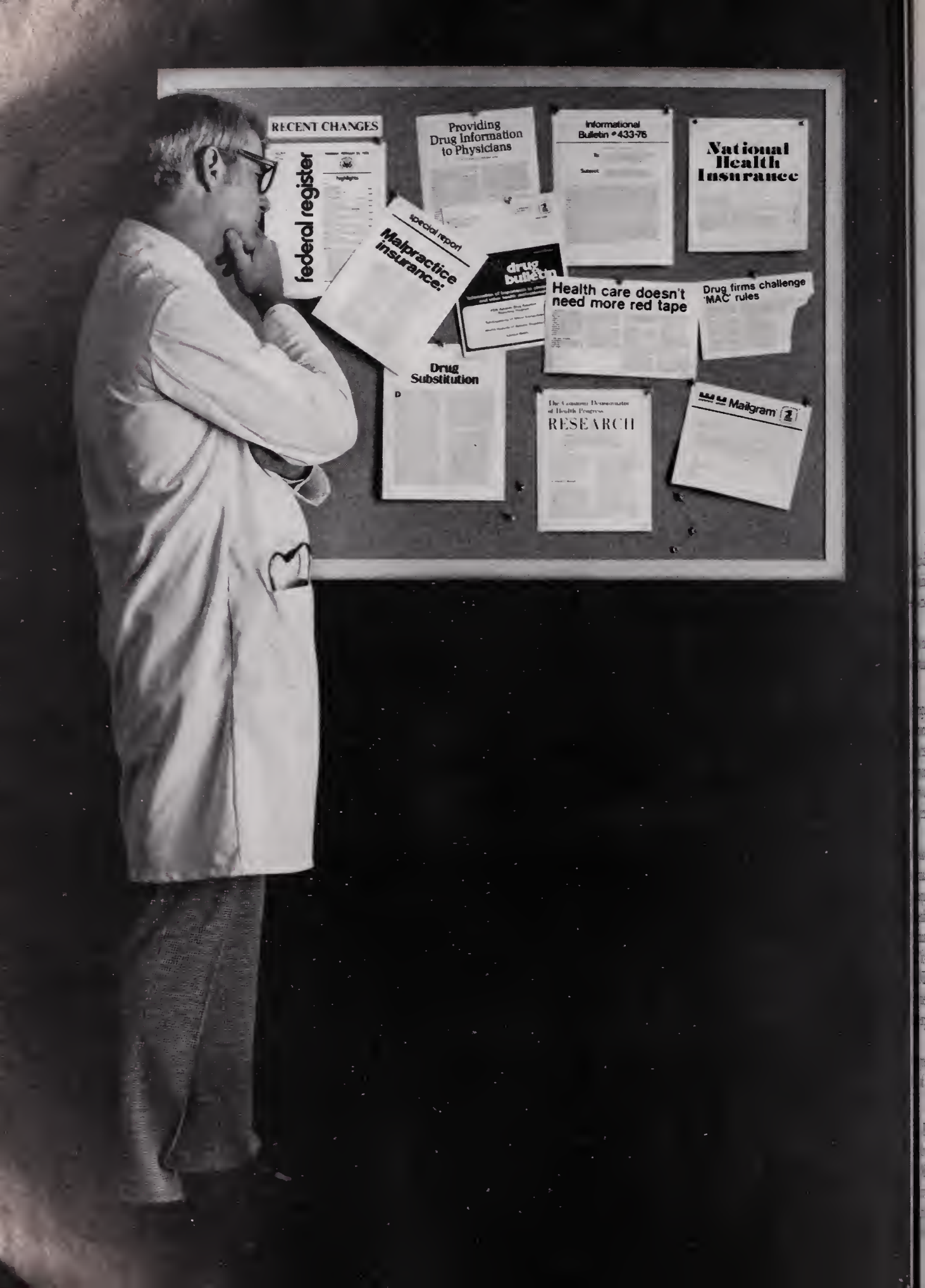
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ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

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The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

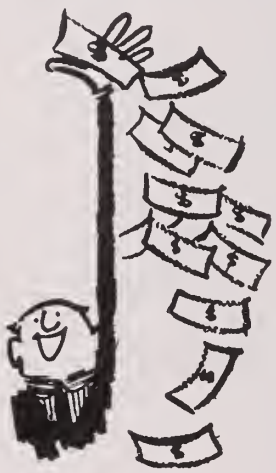
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9:00 a.m. to 9:30 a.m.

Introduction . . . The Importance of Business Essentials

9:30 a.m. to 12:30 p.m.

Telephone management . . . what to say and how to say it; educating the patient about the practice; helpful techniques and useful equipment. Appointment scheduling . . . developing a schedule that works and making it work. Medical records . . . structuring the content; effective filing procedures; dictation aids.

LUNCHEON

12:30 p.m. to 2:00 p.m.

Included in registration fee

AFTERNOON SESSION

2:00 p.m. to 5:00 p.m.

Personnel . . . conflict, cause and cure; utilizing your skills; motivation tips. Billing systems and collections . . . improving patient understanding; improving the collections system. Insurance claims processing . . . defining obligations, finding a better way. Implementation . . . putting it all to work.

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MEETINGS ABOUT MEDICINE

Members of The Medical Society of Virginia are invited tc submit entries for this calendar. The information should bc received five weeks before publication by the Managing Edi- tor, 4205 Dover Road, Richmond VA 23221.

October

Perspectives in **Pediatrics** #2, sponsored by Depart- ment of Pediatrics, University of Virginia School of Medicine, *Charlottesville,* October 14. Office of Continuing Medical Education, Charlottesville 22901.

Neurology for the Practicing Physician, sponsored by Department of Neurology, University of Virginia School of Medicine, *Charlottesville,* October 15-17. Office of Continuing Medical Education, Char- lottesville 22901.

Topics in **Gastroenterology** and **Liver Disease:** Medical and Surgical Aspects, sponsored by the Depart- ments of Medicine and Surgery of The Johns Hop- kins School of Medicine, Johns Hopkins Medical Institutes, *Baltimore,* October 7-9. Willis C. Mad- drey, MD, Blalock 932, The Johns Hopkins Hospi- tal, Baltimore 21205.

Diabetes Day, sponsored by National Institutes of Health, Masur Auditorium, NIH Clinical Center, *Bethesda, Maryland,* October 16. Jesse Roth, MD, Diabetes Branch, NIH Clinical Center, Room 8S- 243, Bethesda 20014.

High Risk **Obstetrics** and **Gynecology,** sponsored by Department of Obstetrics and Gynecology, Uni- versity of Virginia School of Medicine, *Charlottes- ville,* October 22. Office of Continuing Medical Education, Charlottesville 22901.

November

1976 Annual Meeting—The Medical Society of Virginia and Auxiliary, Williamsburg Conference Center, *Williamsburg,* November 4-7. Presiding Officer: Raymond S. Brown, MD, Host Society: Portsmouth Medical Society, Arthur A. Kirk, MD, Chairman of Arrangements.

rspectives in **Pediatrics** #3, sponsored by Department of Pediatrics, University of Virginia School of Medicine, *Charlottesville,* November 11. Office of Continuing Medical Education, Charlottesville 22901.

astrointestinal Problems of Infancy and Early Childhood, sponsored by the Department of Pediatrics, Medical College of Virginia, at St. Mary's Hospital, *Richmond,* November 12. Barry V. Kirkpatrick, MD, Box 276, MCV Station, Richmond VA 23298.

ublic Health Traineeship covering pediatric problems in rural health care, sponsored by the University of Virginia's Children/Youth Program, Ramada Inn, *Charlottesville,* November 15-17. Stipends available. Joseph R. Zanga, MD, Box 148, Charlottesville 22901.

reaking Affective Barriers for the **Handicapped,** sponsored by Virginia Council on Health and Medical Care, Inc., Hotel Roanoke, *Roanoke, Virginia,* November 22-23. Edgar J. Fisher, Jr., Director, Virginia Council on Health and Medical Care, Inc., PO Box 12363, Central Station, Richmond 23241.

December

Recent Advances in **Clinical Medicine,** sponsored by Department of Medicine, University of Virginia School of Medicine, *Charlottesville,* December 1-3. Office of Continuing Medical Education, Charlottesville 22901.

nfectious Disease, sponsored by Department of Pediatrics, University of Virginia School of Medicine, *Charlottesville,* December 9. Office of Continuing Medical Education, Charlottesville 22901.

January

Allergy, sponsored by Department of Pediatrics, University of Virginia School of Medicine, *Charlottesville,* January 13. Office of Continuing Medical Education, Charlottesville 22901.

The Alton D. Brashear Postgraduate Course in **Head** and **Neck Anatomy,** sponsored by the Department of Anatomy in cooperation with the Division of Continuing Education, School of Medicine and School of Dentistry, Medical College of Virginia *Richmond,* January 17-20. Dr. Hugo R. Seibel, Department of Anatomy, Richmond 23298.

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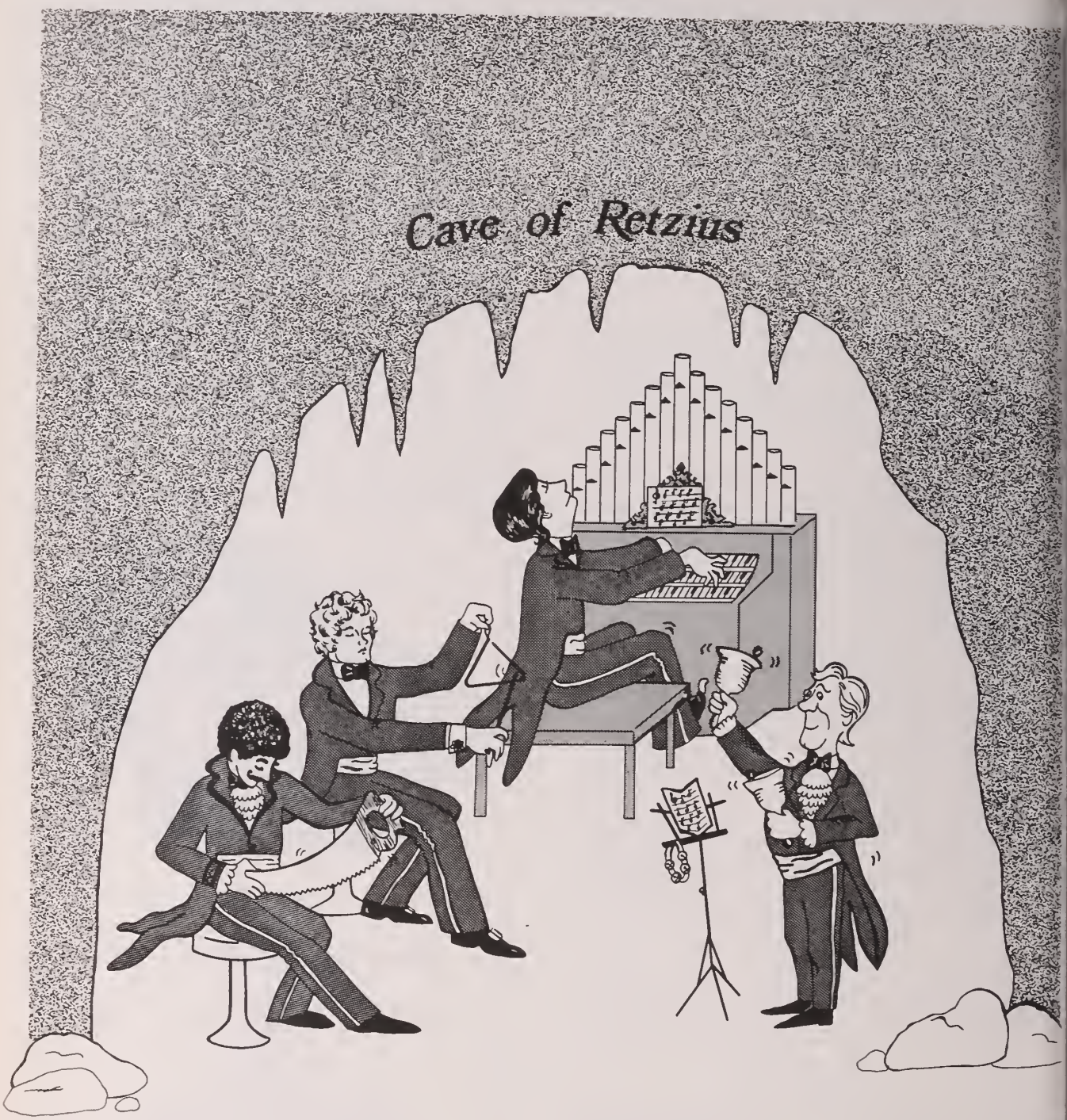


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Anders Adolf Retzius (1796-1860)
Sydney Ringer (1835-1910)

VIRGINIA MEDICAL

EDITORIAL

What's In a Name?

AS A STUDENT, I was weaned on medical-names—Pott and Dover, Colles and Corrigan, aennec and Dupytren, Finsen and Ramstedt, Wasermann, and, name of names, Von Recklinghausen. art of my interest stemmed from two books by Hamilton Bailey which are standard texts in both England and America. One of these books I still ossess—*Demonstrations of Physical Signs In Clinical urgery*. The other, *A Short Practice of Surgery* coauthored by McNeill Love), I lent to a nurse in oronto. I have seen neither the book nor the nurse ince! Mr. Bailey, an English surgeon, had the happy abit of appending a footnote to each page on which name appeared; Dover's powder, for example, was evealed as originating in "Thomas Dover (1660-742), Bristol physician and buccanner".

Apart from the biographical and historical details n the text, the books are written without the usual nedical stuffiness. In discussing rib fractures, for instance, the reader is advised, when in a crowd, to keep his hands in his pockets to protect his ribs *and* his money! An additional curiosity is that I was told hat Mr. Bailey had a finger missing from one hand; certainly in several illustrations, notably those of bimanual palpation, the index finger of the palpator's eft hand is not in evidence.

There are many who decry the use of medical eponyms, but for me, at least, they opened the door to medical history. Where, to begin with, did Thomas Dover perform his piracy? A few minutes with a reference book revealed that he sailed 'round the world with one Captain Woodes Rogers, partaking iberally of the spoils of war which accrued from the voyage—the same voyage that resulted in the rescue of Alexander Selkirk, the original Robinson Crusoe.

I shall be sorry to see eponyms disappear; they add spice to the monotony of pure anatomico-pathological names. Take Percival Pott, another English surgeon. Most of us know that Mr. Pott has a fracture named after him and some of us realize that his tuberculous spine is now rarely seen. But how many of us can describe "Pott's puffy tumor"? And what a delightfully descriptive name it is for the swelling of osteomyelitis of the skullbones. Pott, a leading light of Saint Bartholomew's Hospital in London, must surely be the only doctor honored with three eponyms.

Recently, there have been two "eponoymous" books written by Wallace Reyburn which capture the imagination although they are only distantly related to the true medical eponym. One of these is about Thomas Crapper and the other about Otto Titzling.

Thomas Crapper was a nineteenth century artisan who reached the heights of his trade when his product was blessed by loyalty. He began as a plumber in a small way but soon perfected a patented "Water Waste Preventer" which improved the efficiency of the Victorian toilet. He did not invent the water carriage system; this was done by the gay (in the old sense!) blade, Sir John Harington, a godson of Queen of Elizabeth I. *Flushed With Pride,* as the book title says, Crapper received the Royal Warrant as "Sanitary Engineer" to Edward VII. His name, strangely enough, is a common slang term in America but not in England.

There is no true eponym attached to Otto Titzling but the play on words is only too obvious—he is said to have invented the brassière! In his book, *Bust Up,* Reyburn describes the evolution of this vital part of a woman's armamentarium, suggesting that it was popularized, but not invented, by Philippe de Brassière.

To return to the Medical eponym and Hamilton Bailey, anyone interested in the subject should consult Bailey and Bishop's book, *Notable Names in Medicine and Surgery,* which has just been republished.

Fred J. Spencer, MD,
Richmond, Virginia.

Some Reflections on Medical Education

WHEN TWELVE PERCENT of the doctors of this typical American community must be foreign-trained to fulfill its medical needs, and many of its sons and daughters, well qualified to study medicine, can find no place in medical school, a crisis in American education exists. The public wants an explanation and remedy.

I propose to discuss the bottle-necks in medical education and their removal.

We can expect our new doctor of medicine to have a general knowledge of the form and function of the body in health and disease, and of the principles of treatment. These acquisitions are no more than the basics for his continued professional growth, the details being constantly modified, deleted or added.

Specifically, we can expect the new doctor to have passable skills in history-taking and in general physical diagnosis, with an understanding of the anatomico-pathophysiology of his findings. Rather than a knowledge of Yersinia, anisakiasis, and Armillifer armillatus (yes, all three are found in the United States), it would profit him and the community more to be skillful in using the girders of his profession: the ophthalmoscope, laryngoscope, sigmoidoscope and the pelvic examination.

We passengers on this good space ship Earth have finally realized that the day of profligacy with her natural resources is finished; acceptance of the need for husbandry of her human resources is sure to follow. Cost accounting, even in professional training, must be the order of the day.

The first bottleneck in medical education occurs in the preclinical years. Restructuring and streamlining these years would allow more bench space for more students, without serious distortion of the student's appreciation of the scientific method. The hours devoted to gross anatomy have been greatly reduced with no appreciable effect on the quality of the final product. Similar surgery could be applied to the other laboratory subjects. Stylized laboratory exercises that consume hour upon hour, whose idealized end-results are known beforehand to one and all, must be subjected to constant scrutiny: while interesting in themselves, are they worth the time consumed in producing the doctor?

The second bottlneck in medical education occur in the clinical years and is more wasteful and mor inexcusable since it could more easily be remedie than the first. Clinical facilities limiting the number c medical students is a fiction. The medical educato has only to go into the field to visit our good commu nity hospitals and study the caliber of their medicin to see the many educational potentials that lie fallow It is painful, for example, to witness the absence o medical students from my own department of radio logy, run by university standards, with a ratio o radiologists to patients as high as any and with facil ities 90% adequate for residency training in radio logy, let alone for the indoctrination of medical stu dents. Indeed, the tools of the ideally trained docto are just as well, if not better, acquired in the setting o the community hospital than of the university. It is ir the community hospital that the medical studen better learns that the *uncommon manifestation o the common is commoner than the common manifesta tion of the uncommon,* a lesson that will serve him wel the rest of his career. Any attempts by the medica schools to tap this vast pool of clinical material anc teachers in the community hospitals have been toc small and too few.

Of course, the experiences of the medical student in the community hospital should be subject to the continuous supervison of the university representative in residence, else the university would be abrogating its responsibility and duty; and it goes without saying that a good part of the student's clinical time should be spent in the university milieu because he is there best touched by the spirit of medical inquiry and discovery, the life-blood of medical education.

In summary, the limited resources of the medica school must be husbanded at the preclinical level, anc the resources of the superior community hospitals must be utilized at the clinical level. With these changes, a greater number of qualified students may be admitted to medicine with no great increase in existing facilities and with no serious diminution in the quality of the product.

Christian V. Cimmino, MD
Fredericksburg, Virginia

LETTERS TO THE VIRGINIA MEDICAL EDITOR

The Editor is pleased to publish the expressions of readers on any subject of concern. Type in double space, please. Brevity is much admired. Address the Editor at 1205 Dover Road, Richmond VA 23221.

Malpractice Defense: A Suggestion for Change

AN OLD AMERICAN TRADITION had it that the Constitutional guarantee of a jury of the defendant's peers actually consisted of anyone in the community. This probably evolved from the American concept that all citizens are equal. Not long ago some citizens raised objections to that custom, asserting that a jury cannot be acceptable when a minority defendant faces an all-white jury. At first we laughed at this idea—just as we laugh at all strange new ideas. Yet today it has become customary to mention how many non-white jury members are provided.

If ethnic background can be used as a basis for demanding a jury of one's peers, I believe other considerations also can be used. This can be true only if it is requested. With the ethnic demand for change, disorderly conduct was resorted to; I hope I am not advocating the same here. Instead, if a request is denied, it may be a basis for appeal.

Lawyers have been taking full advantage of juries who know nothing of the technical intricacies of medical matters. After a defendant presents scientific details, a pseudoscientific rebuttal is presented, which confuses the jury. It is completely unreasonable to expect a person lacking training or experience to detect which information is factual and which is spurious. Juries have been discounting both presentations, and giving verdicts based only on their emotions. This is certainly contrary to the intent of a jury of the defendant's peers and is certainly a denial of a Constitutional right.

I propose that no defendant who is accused of a wrong that is based on a highly technical detail can be properly tried by a jury, not one member of which has had some technical training and experience in a related technical field. Such a jury has no member who could possibly be accused of a similar error and therefore cannot understand the defendant's position. This is identical to the ethnic complaint and should have the same relief.

I do not suggest that a physician must be on the jury. There is a reasonable range of possibilities to fit the description, so that a court can respond. The Roster of Practitioners published by the State Board of Medicine includes a listing of osteopaths, podiatrists, naturopaths, clinical psychologists, chiropractors, physical therapists and physical therapist assistants. In addition, there are many nurses, pharmacists, laboratory technicians, x-ray technicians, respiratory therapists, biologists and perhaps others who have technical training in an allied field and who have an understanding of anatomy, physiology, medication or other technically related matters.

Malpractice suits are having the effect of destroying the availability of medical care to the public. It is the duty of any court to protect the public from those actions which are against public policy or welfare. In every malpractice case, the defendant should start by requesting a jury of his peers. Some day this provision could be customary.

C. H. Doughtery, MD,
Hopewell, Virginia.

Another Vote Cast on Compulsory Membership

I enjoyed very much Dr. R. G. McAllister's letter to the Editor of the Virginia Medical Monthly of August, 1976. I agree with his statements wholeheartedly and have already expressed similar sentiments to the Roanoke Academy of Medicine, and fortunately the Board of Directors of the Academy voted to take no action on this matter of compulsory membership in the AMA.

I certainly hope that more people will come forward and express their views as Dr. McAllister did.

James E. Comer, Jr., MD,
Roanoke, Virginia.

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VIRGINIA MEDICAL OBITUARY

Robert P. Beckwith, Jr., MD

At the age of 57 years, Dr. Robert Payne Beckwith, Jr., Richmond, died July 29 in a Richmond hospital. Dr. Beckwith had been associated with McGuire Veterans Hospital, Richmond, for 28 years; on his retirement because of illness in 1972 he was chief of the outpatient department. He also maintained a private practice, specializing in cardiology and internal medicine.

Known familiarly as "Buddy", Dr. Beckwith was born in North Carolina, attended the University of North Carolina at Chapel Hill and received his doctorate in medicine from the Medical College of Virginia in 1943. He was a member of The Medical Society of Virginia and the American Medical Association.

James M. Hutcheson, Jr., M.D.

Dr. James Morrison Hutcheson, Jr., Richmond, died August 3 in a Richmond hospital at the age of 54 years.

A native Virginian, Dr. Hutcheson was schooled at Washington and Lee University and the University of Virginia School of Medicine, taking his training at hospitals in Galveston and Boston and joining his father in practice in Richmond in 1955. At his death he was an associate medical director of the Life Insurance Company of Virginia.

He was a member of The Medical Society of Virginia, the American Medical Association, and the Association of Life Insurance Medical Directors.

Hugh Rodman Leavell, MD

At the age of 73 years, Dr. Hugh Rodman Leavell, Richmond, died August 7 in Richmond.

Dr. Leavell was a native of Louisville, Kentucky. After schooling at the University of Virginia and the Harvard and Yale Medical Schools, he entered a distinguished career in public health. In Louisville he served as city director of health and taught at the University of Louisville's medical school. In 1946 he joined the Harvard School for Public Health, holding for 17 years the post of head of the department of public health practice. He then joined the Ford Foundation as a consultant to India's Institute of Public Health Administration and Education in New Delhi. He came to Richmond in 1969 to become associated with the Medical College of Virginia's department of preventive medicine and with the State Department of Health.

He was a fellow of the American College of Physicians and a diplomate of the National Board of Medical Examiners and belonged to the American Academy of Arts and Sciences. He became eligible this year for membership in The Medical Society of Virginia's 50-Year Club.

Colin MacRae, MD

Dr. Colin MacRae, Alexandria, noted as being the first pediatrician in Alexandria, died December 11, 1975, in the Johns Hopkins Hospital following a long illness.

Dr. MacRae was born in 1907. He was a native of Wilmington, North Carolina. His great-grandfather, Dr. Orlando Fairfax, practiced in Alexandria prior to the Civil War. Dr. MacRae received his premedical education at Gilman in Baltimore and at Princeton University, his medical degree from Johns Hopkins in 1934 and his pediatric training at New York Hospital.

Dr. MacRae started his practice in Alexandria in 1938. He served in the Army at Fort Monroe and in the Pacific theatre during World War II. He remained in active practice until serious illness forced his retirement in July of 1971. He served his community as a member and chairman of the Board of Health. His hours of service in the Community Clinic exceeded that of any of the staff. He was president of the Alexandria Medical Society. Dr. MacRae was chief of the medical staff at Alexandria Hospital, chief of the department of pediatrics at Alexandria Hospital and chairman of the board of the Community Clinic.

The Distinguished Physician Award was presented to Dr. MacRae in 1973. This was recognition of his influence and achievements during his long and remarkable medical career. Dr. MacRae was a life-long member of the Episcopal church. He served as vestryman and senior warden of Emmanuel-on-the-Hill Church in Alexandria.

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WHO'S WHO IN VIRGINIA MEDICINE

Dr. Paul M. Suratt of the Department of Internal Medicine, University of Virginia School of Medicine, *Charlottesville*, is coauthor of a study published recently in CHEST entitled, "Deaths and Complications Associated with Fiberoptic Bronchoscopy." The other authors are Brian Gruber, Charlottesville, a medical student, and Dr. Joseph F. Smiddy, Kingsport, Tennessee.

For the study, questionnaires were sent to over a thousand owners of fiberoptic bronchoscopes requesting data; 323 of these were returned, listing 48,000 procedures with many complications and ten deaths. All patients who died had either myocardial disease, severe chronic pulmonary disease, serious pneumonia or cancer. Two deaths were associated with evidence on necropsy of fresh myocardial infarctions previously unsuspected. Two deaths occurred after administration of local anesthesia prior to bronchoscopic examination, and two were patients who had previously had slowly hemorrhaging tumors that hemorrhaged massively after forceps biopsy and saline lavage. Four brushes broke off in bronchi. Ten cardiac arrests and 41 life-threatening reactions to anesthesia also occurred.

He's 86 years old and still in active pediatric practice: **Samuel Newman, MD,** *Danville*. In recognition of Dr. Newman's long and generous community service, a portable incubator recently was donated in his honor to the Memorial Hospital of Martinsville and Henry County. The donor was the Charity League of Martinsville, for whom Dr. Newman conducted medical clinics for indigent children for more than 30 years; the League paid $1,400 for an incubator that is mounted on a collapsible frame so that it can be loaded into ambulances and other vehicles. Dr. Newman, a 1917 graduate of the University of Virginia Medical School and a member of The Medical Society of Virginia's 50-year Club, also conducted similar clinics for Danville area children for many years.

Charlottesville has its first woman mayor and she is the wife of a physician. Mrs. Nancy K. O'Brien, former RN and mother of four, became involved in politics through the League of Women Voters; this led to her appointment as chairman of a district planning commission, where her effectiveness prompted a group of citizens to ask her to run for city council. She campaigned—and won—by shaking "every hand in sight," and the council then elected her mayor. Mayor O'Brien is married to **William M. O'Brien, MD,** MSV member and professor of internal medicine at the University of Virginia School of Medicine.

Dr. Fritz E. Dreifuss, *Charlottesville*, has accepted appointment to the Commission for the Control of Epilepsy and its Consequences, according to the Epilepsy Foundation of America's newletter. He is professor of neurology at the University of Virginia and clinical director of the Commonwealth of Virginia's Child Neurology Program.

William T. Cave, Jr., MD, and **John T. Dunn, MD,** *Charlottesville*, are coauthors of an article in a recent issue of *Annals of Internal Medicine*. Its title: "Choriocarcinoma with Hyperthyroidism: Probable Identity of the Thyrotropin with Human Chorionic Gonadotropin." Their study documents the history of a 15-year-old girl who developed severe hyperthyroidism secondary to metastic choriocarcinoma. Their results suggest that the thyrotropin of choriocarcinoma is HCG.

David B. Propert, MD, *Richmond*, has been granted Fellowship in the American College of Cardiology. His admittance was announced recently by **Richard S. Crampton, MD,** *Charlottesville*, ACC governor for Virginia.



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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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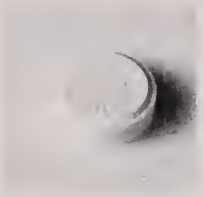
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severely depressed, or with latent
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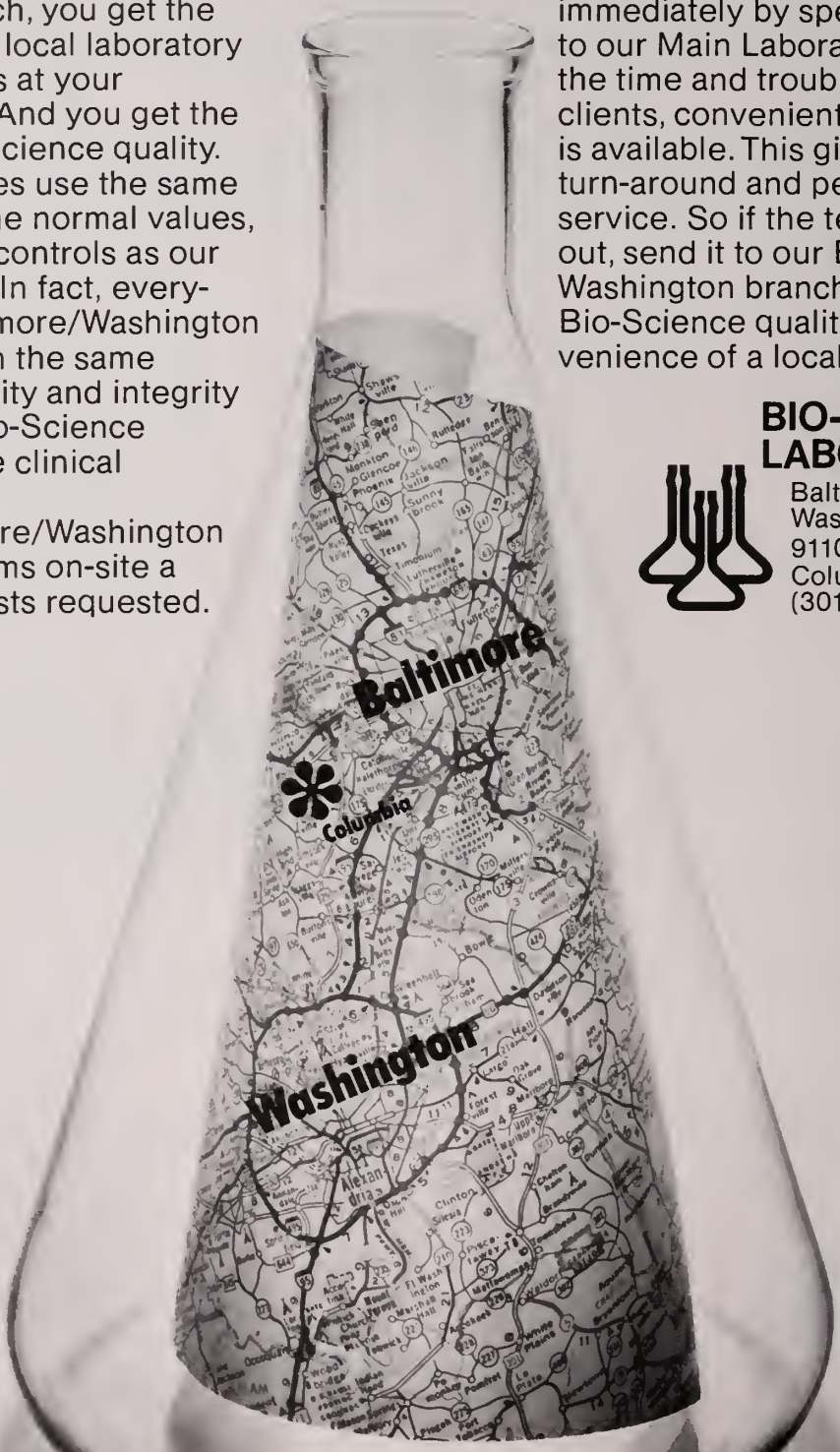
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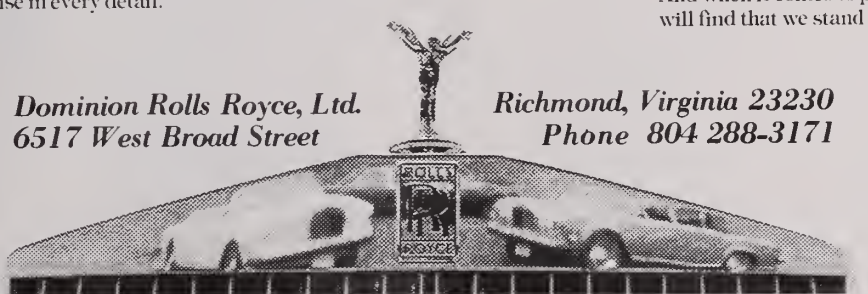
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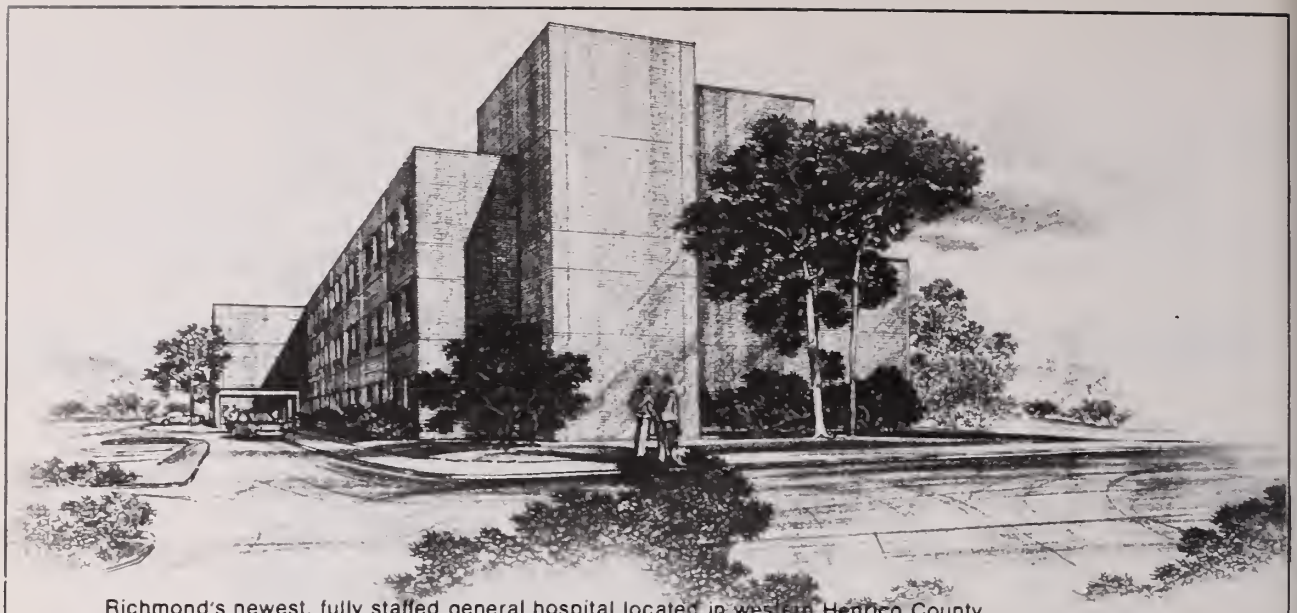
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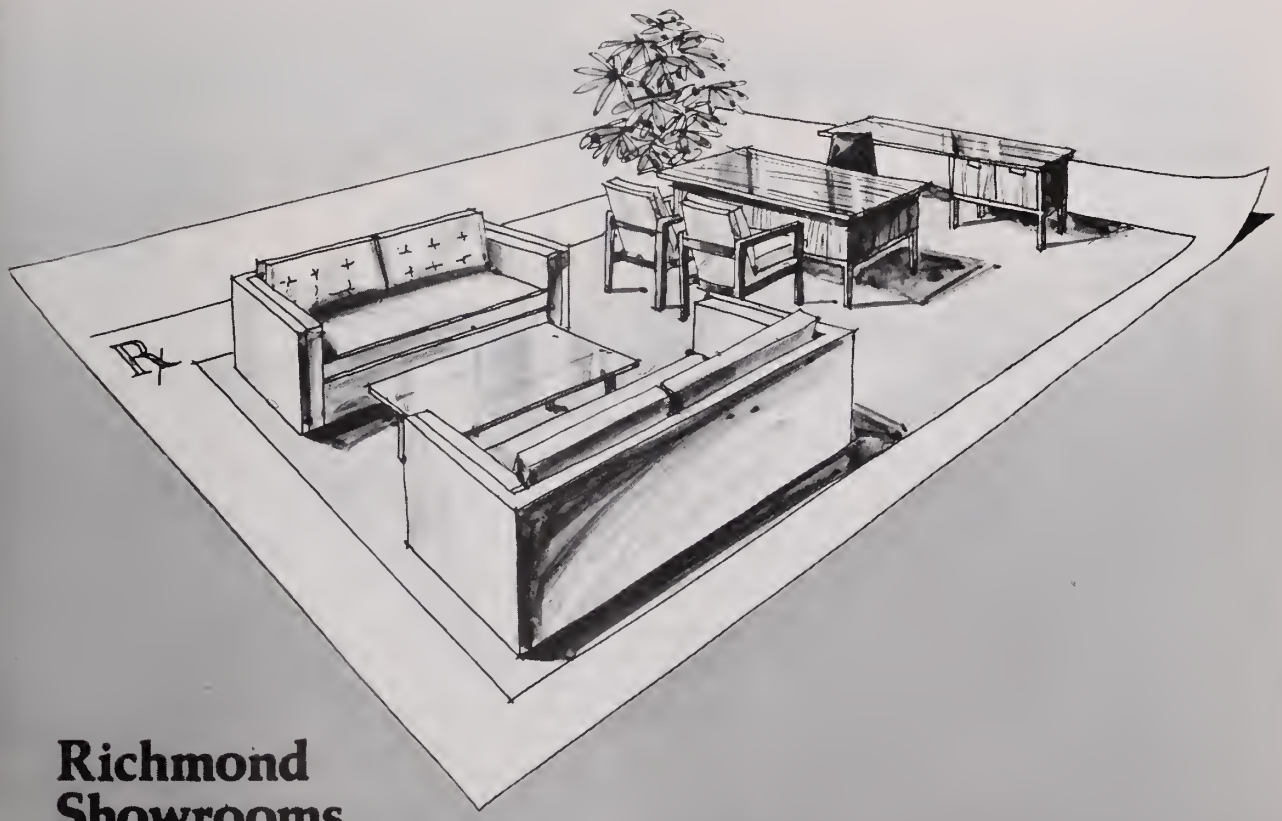
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Here in the Virginia Company, C & P plans to insert the guide in the Yellow Pages of Roanoke, Danville, Richmond, Lynchburg, Norfolk, Virginia Beach and Peninsula. All physicians served by these directories will be contacted and offered an opportunity to list under their specialty within this medical specialty guide.

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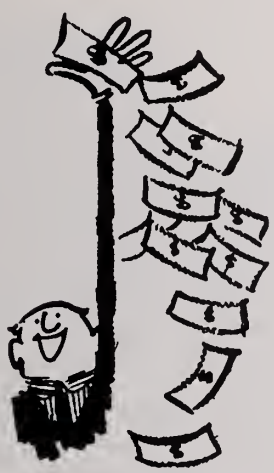


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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

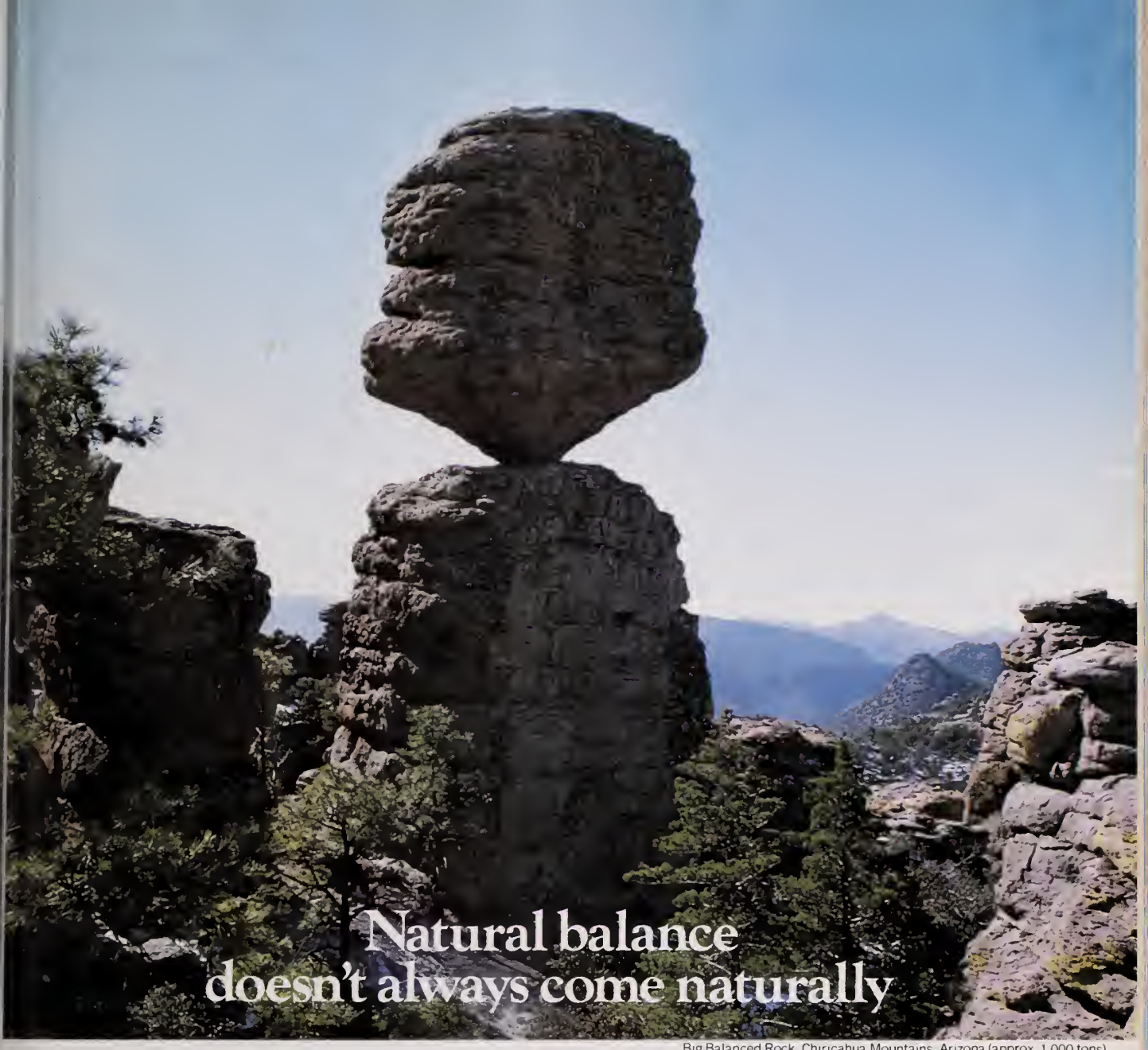
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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VIRGINIA MEDICAL

ne 103 November, 1976 Number 11

"An Honor and a Pleasure to Serve You"

Raymond S. Brown, MD, *Gloucester, Virginia,*
President, The Medical Society of Virginia

". . .we are meeting here in Williamsburg. . .a fitting place for Brown to say farewell to his troops! . ."

ON OUR COUNTRY'S 200th anniversary, it is especially appropriate that we are meeting here in Williamsburg. Here so much of our nation's history took place. Nearby, across the York River at Rosewell, tradition has it that Thomas Jefferson wrote the first draft of the Declaration of Independence. A few miles down on this side of the river, the last battle was fought at Yorktown. Now it is a fitting place for Brown to say farewell to his troops!

It has been an honor and a pleasure to serve you this Bicentennial Year. For most of the good things that have happened, give credit to Bob Howard and his effective staff, to all the officers and Council, and especially to Bill Hill and Len Weyl. All sins and omissions are mine.

Prepared for presentation before the House of Delegates of The Medical Society of Virginia at the Annual Meeting, Williamsburg, November 4, 1976.

I know you all share my appreciation to Dr. Thompson, successor to that able Editor, Dr. Harry Warthen, and to Mrs. Ann Gray, Managing Editor, for their capable work on the VIRGINIA MEDICAL MONTHLY. Incompletely, but lastly, I owe a deep debt of gratitude to my personal staff and to my family for their forbearance, especially to my wife, Elizabeth, who neglected her daffodils and many other things for the good of The Medical Society of Virginia.

We had an energetic encounter with the Virginia legislature, an interesting opportunity to all who participated. Doctors from all over the state, but especially from Northern Virginia, Norfolk and Richmond, appeared before the General Assembly. With one or two stubborn exceptions, I was very impressed by the honesty, sincerity and diligence of our legislators. You are well aware of what was accomplished. Certainly much more will have to be accomplished if

"... We must continue to study ourselves and to change ... so that all physicians in Virginia will feel a need to become members of the Society ..."

legislation is to be of help in this professional liability crisis. This should remain Item One on the agenda of future officers.

Like all other physicians, I am concerned that so many of the decisions of our malpractice problems are made by lawyers. Many of them do not handle malpractice but are occasionally involved peripherally by referral to specializing lawyers from whom they receive a referral fee.

The Legislative Seminar in Charlottesville in April gave more of our members the opportunity to learn about the Virginia legislative process and to meet some of the influential members of the General Assembly of Virginia. I thank the Smith, Kline & French company for its help in organizing and supporting this beneficial seminar.

The Society passed the 5,500 mark this year, but there remains a substantial number of Virginia physicians who should be members of The Medical Society of Virginia and are not. We must continue to study ourselves and to change as the times dictate, so that all physicians in Virginia will not only feel a need for, but a duty to, become members of the Society. The importance of all physicians contributing to the cost of representing medicine must be recognized, so that a large percentage of our physicians are not freeloaders on those who do pay their way by membership in The Medical Society of Virginia and the American Medical Association.

The Council, and especially the Long-Range Planning Committee, has been and is working on this problem. It regularly makes recommendations which, if implemented, should improve the Society's ability to function as the Voice of Medicine in Virginia. In this area, specifically, it would seem that some additional remuneration for the more active officers of the Society might be in order. We need the advantage of younger men vying for these positions. Some of the younger physicians say now that they could not afford to be President of The Medical Society of Virginia because of the loss of income. This is regrettable.

As you know, there are plans for enlargement of the existing office in Richmond. I feel these plans should be implemented as soon as practical. Mr. Howard's reorganization of his staff is now complete. This will increase the efficiency of an already efficient organization.

The Medical Society of Virginia participated in a testimonial dinner to one of our most distinguished members, Dr. Mack Shanholtz, when he retired as Commissioner of Health for Virginia. This was a pleasant and moving occasion for all who attended.

The Bicentennial Exhibit, conceived and created by Dr. Harry Warthen and his committee and subsidized by the A. H. Robins Company, the Richmond Academy of Medicine and the Society, is being well-attended and widely complimented.

The subject of disciplinary action of physicians by physicians outside of the usual channels requires continued and careful discussion, with ultimate decision.

Your President had the opportunity of speaking to various groups and utilized these occasions to voice a personal philosophy about the American economy and about medicine. The talk to the Virginia Congressional Assembly has been printed in the VIRGINIA MEDICAL MONTHLY, and the speech to the Bar Association in the Virginia Bar Association Journal.

I would like to enlarge briefly upon the theme that one of the causes of the increasing costs of medical care is the by-passing of the market economy principle by first-dollar coverage. The patient has been sold the idea that he can budget for known future expenses through the purchase of health insurance (which, of course, should be correctly termed "sickness insurance"). When an individual budgets for his own needs and puts the money in the bank, he will not casually spend this money. But when he pays these dollars to an insurance company, he feels the need to use up the money that he has so invested. Small deductibles are not going to solve this problem. Substantial deductibles might do so. The argument that this denies the poor person access to medical care is valid in the short term, but if current inflationary pressures in the health care field bring on socialized medicine or a catastrophic breakdown in the system due to the increased cost, these poor will suffer as much or even more than anyone else.

An interesting problem right now is the cost of the computer-assisted tomography studies that are being ordered in such increasing numbers across the country. This threatens to overwhelm the insurance programs. A solution here would be for the insurance companies not to pay for the CAT scans. Physicians would then have to evaluate the need for the scans more carefully, and the patient would have to be prepared to pay the cost. Under this method, the inevitable law of supply and demand would begin to function, the cost would come down and efficiency would go up.

The concept of "Tragedy of the Commons" has been discussed in relation to government grants. It



RAYMOND S. BROWN, MD, PRESIDENT, 1975-1976.

"...We have operated in this country for so long under the assumption that our every want can be satisfied, that our resources are infinite..."

seems to me it now applies also to sickness and hospital insurance. We have operated in this country for so long under the assumption that our every want can be satisfied, that our resources are infinite. Now, as we find that oil, energy and medical care are limited, we are trying to replace the free economy—which is the only thing that has ever produced equitable distribution of limited resources—by committees, such as PSRO and HSA Certificate of Need Committees, and by governmental regulations, such as the Utilization Regs. These committees work ineffectively and expensively. In my opinion we need less Washington in our profession. From there, as you are well aware, come the three biggest put-offs:

"I was just going to call you back."

"The check will be in the mail tomorrow."

"I am from Washington, and I am here to help you."

I found recently Ralph Bradford's paraphrase of one of Omar Khayyam's quatrains. I think it has profound comtemporary meaning:

And are you then so weak and self-forsaken
You turn for succor to the vast but shaken
And barren branches of the State? Beware,
It cannot give a thing it has not taken!

Members of the House of Delegates, other members of The Medical Society of Virginia, guests and friends: Thank you for this opportunity to have served you, and I wish Godspeed to The Medical Society of Virginia in the year ahead. ■

75 Years Ago . . .

From the VIRGINIA MEDICAL SEMI-MONTHLY, October 25, 1901.

The announcement of the thirty-second annual session of the Medical Society of Virginia, issued too late for incorporation in our last issue, is very attractive. The session is to be held in the Masonic Home building, Lynchburg, Va., November 5, 6, and 7, 1901, beginning at 8 P. M. Tuesday, November 5th. Dr. Samuel C. Busey, Lynchburg, is chairman of the Committee of Arrangements. He states that ample hotel accommodations in easy reach of the hall of meeting have been provided—the Carroll Hotel at $2.50 per day, and the Arlington Hotel at $2 per day. Those who prefer private boarding houses can be provided for by writing in advance for such. Ample arrangements have also been provided for exhibitors. Those desiring space and rates should at once write to the chairman of the Committee of Arrangements.

The railroads generally have agreed to a rate of *four cents per mile, round trip,* in the sale of tickets to Lynchburg for this session.

Officers of the Society for current year:

President—Dr. J. R. Gildersleeve, Tazewell Va.

Vice-Presidents—Drs. J. H. Neff, Harrisonburg, Va.; J. E. Copeland, Round Hill, Va.; and Charles W. Pritchett, Danville, Va.



JOHN R. GILDERSLEEVE, MD, PRESIDENT, 1901

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Construction or Conversion: Which Way for Virginia's Medical Facilities?

Robin E. MacStravic, PhD, *Richmond, Virginia*

"... Specifically, should the state see to it that new long-term care and outpatient facilities are constructed while retaining 2,632 superfluous hospital beds? ..."

The Medical Facilities Plan here discussed is required by PL 93-641, the National Health Planning and Resources Development Act. It serves as the successor to the Virginia Plans for Construction and Modernization of Medical Facilities or Hill-Burton plans.

THE VIRGINIA MEDICAL Facilities Plan has been published by the State Department of Health. According to the September, 1976, interim version, the state suffers from an overabundance of hospital facilities a shortage of long-term care facilities and a severe shortage of outpatient facilities. While serious questions can be raised regarding the techniques employed to reach these conclusions, the findings themselves raise an interesting question: should each type of facility be developed independently or are they in some cases convertible?

Hospital Facilities Needs

The basic methods used to determine medical facilities needs in Virginia are traditional and suffer from serious drawbacks. The need for hospital beds, for example, is determined entirely on the basis of current utilization. The total number of inpatient days of care rendered by hospitals in a given area is divided by the population of that area to yield a "use rate." This use rate is then applied to future population projections to estimate future utilization. Bed needs are then determined on the basis of how many are required to serve the estimated utilization and maintain 85% occupancy of the facilities.

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While this approach is simple and popular, it suffers from serious fallacies of logic. It assumes, for example, that all existing utilization is appropriate, with no wasteful occupancy and no unmet needs. If many people are occupying hospital beds unnecessarily because of a lack of nursing home beds (and the Plan itself concludes there is a shortage of long-term care beds), then current use rates may be inappropriately high. If some people are not receiving needed hospital care because of inability to afford it or lack of access to a physician who can detect that need, then current use rates may be inappropriately low. Even if current use is totally appropriate, why should the same rate hold for the future? Moreover, why should 85% be accepted as a target for all hospitals? Small hospitals or units of hospitals rarely achieve occupancy levels so high, while larger hospitals and units may surpass them easily.

Long-Term Care Needs

The technique used to measure needs for long-term care beds is similar. Use rates are calculated on current utilization and the over-65 population. Projections are based on future population over 65 years of age. A 90% occupancy is then set as a basis for translating utilization into bed requirements. This method assumes that only people over 65 need to receive long-term care.[1] Yet studies have indicated that many people under 65 do, and many more should, receive long-term care. One study[2] indicated that over half the people kept in hospitals should have been transferred to long-term care. As with hospital utilization, no attempt is made to judge whether existing utilization represents appropriate use of long-term care or whether current rates are



likely to persist into the future. The 90%-occupancy figure is probably a conservative one, since stays in nursing homes are long and admissions are subject to scheduling. As an alternative, the plan suggests that a ratio of 30, 40 or 50 beds per thousand people over 65 be used to augment the use rate formula. The choice of ratios is based on whether the area under consideration is rural, urban or metropolitan. No other factors are recognized.

Outpatient Facility Needs

The need for outpatient facilities is determined by the most dubious technique of all. The method employed assumes people should use outpatient facilities at a rate of roughly 300 visits per 1000 people per year. This use rate is then applied to future populations to predict future use. The number of facilities needed is determined by a complex, though not difficult, formula reflecting the number of patients which can be seen in an examining or treatment room per day, the number of rooms each facility should have and the number of days each facility should operate.

The greatest fallacy behind this approach is the assumption that people "need" outpatient facilities. To the contrary, we need ambulatory care services, rendered by physicians and other health professionals. These services may be rendered in physicians' offices, clinics, emergency rooms, primary care centers, health departments or wherever we choose to seek and are able to find the services required. To construct outpatient facilities on the assumption that we should and will use 3/10 of a visit per person per year assumes a standardization of behavior that is neither desirable nor likely.

Additional problems exist in the application of this approach. An "outpatient facility" is defined in the 1973-74 Plan as having 3-5 treatment/examining rooms, each of which can serve 8-12 patients per day. With a range of rooms and a range of capacity, you get a range of production for each "facility," from

6,000 to 15,000 per year over 250 days of operation. Depending on which is used, we would need from 106 to 257 such facilities to serve the estimated 1980 population of 5,147,600 persons. Since 234 facilities are called for in the Plan, a low production figure was obviously used (actually 6,600 visits per facility per year).

The Plan then reports 129 existing outpatient facilities. Though no figures are cited, each is apparently treated as if it corresponds with the original definition of an outpatient facility and provides 6,600 visits. According to the 1975 American Hospital Association Guide, the 7,174 hospitals in the US provided an average of 34,915 visits apiece, and not all hospitals have outpatient departments. While counting variations may be behind some of these discrepancies, they point out the difficulty of using any kind of standard definition of what an outpatient facility is, who uses it, how many visits it provides, etc.

Findings

As a result of applying these methodologies, the Virginia Medical Facilities comes to the following conclusions:

Hospitals. There are 2,632 more hospital beds licensed or approved in Virginia than are needed for 1980. This represents a 14.6% surplus.

Long-Term Care Facilities. There is a shortage of 1283 long-term care beds relative to 1980 needs. This means a 6.7% increase in existing beds is needed.

Outpatient Facilities. There are only 129 such facilities available, compared to a need for 234. Thus an increase of 105, or 81%, is needed to serve 1980 needs.

Aside from the questionable bases used to arrive at the conclusion that we have too many hospital beds and too few long-term care beds and outpatient facilities, there remains the question of what do we do about it. If we are willing to assume even for argument's sake that the reported findings are reasonably accurate, what action should we take? Specifically, should the state see to it that new long-term care and outpatient facilities are constructed while retaining 2,632 superfluous hospital beds?

If the hospital beds are truly unnecessary, then shouldn't we do something about them? Wouldn't it be less costly to the community to convert unneeded hospital beds to long-term care or even convert patient rooms into examination and treatment rooms? Indeed, PL 93-641 specifically provides for financial support for such conversions. And long-term care beds in a hospital setting have the advantage of greater access to emergency services, to laboratory and x-ray services, to the attention of physicians, etc. As long as the facility exists, it may well be better to use beds for long-term care than have them sit idle while new long-term care beds are built.

Conversion to outpatient care would also offer distinct advantages. Ambulatory care would be rendered where life-support and ancillary services already exist. Medical records could easily be exchanged from inpatient to outpatient care. Moreover, physicians could move back and forth from inpatient to outpatient care without excessive travel between hospital and clinic. A hospital which had converted some beds to long-term care and others to outpatient treatment rooms would be in a position to offer an effective mix of levels of patient care within one facility. This variety of levels of care is listed specifically in PL 93-641 as one of the ten national priorities for health services development.

If there is even a possibility that excess hospital beds can be converted to other uses, perhaps we should wait before we rush to spend funds for new long-term care or outpatient facilities. A surplus of 2,632 hospital beds could eliminate the deficit of 1,283 long-term care beds. If we truly want to have an additional 105 outpatient facilities, with from 315-525 examination and treatment rooms, we should be able to get that many without any additional construction by converting the appropriate number of hospital patient rooms. Such conversions won't always be possible, nor invariably preferable to starting from scratch. But until we take a look at where and when such conversions might work, we might be better off to go slowly in authorizing the construction of 1,283 new nursing home beds and 105 new outpatient facilities. We pay for hospital beds even when they're empty. Wouldn't it be better to have them full?

Overall, there are at least two reasons to reconsider whether the State Medical Facilities Plan ought to be used to control the development of medical facilities. First, its analysis and conclusions are open to serious question as to whether they truly reflect the extent of need. Second, even if the conclusions are correct, we might be able to convert unnecessary facilities to more appropriate use, rather than creating additional resources for one purpose while others stand idle. Ultimately, we all pay for superfluous facilities, via health insurance premiums and tax dollars. If we're going to spend money, we ought to be sure we get the most we can for it.

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INITIAL CARE OF THE SEVERELY BURNED PATIENT

1. TREAT BREATHING DIFFICULTY

- OBSTRUCTED AIRWAY

Rx — Hyperextension of Neck
— Nasotracheal Tube, if necessary

- CONSTRICTING ESCHAR OF CHEST

Rx — Escharotomy

- INHALATION INJURY
  (Burns of Face and Lips, Singed Nasal Hairs, Brassy or Sooty Cough, Cyanosis)

Rx — Obtain Arterial Blood Gas (3 min. after breathing room air)
If $pO_2 < 80$ mmHg – Signs of Respiratory Failure
Rx — Nasotracheal Intubation with Ventilatory Support

2. ESTABLISH CIRCULATION

- ABSENT PULSE

Rx — CPR

- PALPABLE PULSE

Rx — Establish I.V. Line with #18 percutaneous plastic catheter using Ringer's Lactate without glucose.

3. PERFORM HISTORY AND PHYSICAL EXAMINATION

TYPE OF BURN (Chemical, Thermal, etc.)
PERCENTAGE AND DEPTH OF BURN SURFACE AREA (Rule of Nines)
CHECK FOR OTHER INJURIES

4. PREVENT BURN SHOCK

Rx — Calculate Fluid Replacement for first 8 hours after injury
2 ml Ringer's Lactate x kg. wt. x % Burn Surface Area
Urine Output via Foley Catheter should be maintained at:
Adult—30-40 ml/hr.
Children—10-15 ml/hr.

5. PALPATE PULSES IN CIRCUMFERENTIALLY BURNED LIMB

- PULSELESS EXTREMITY

Rx — Escharotomy

6. TREAT ILEUS

Rx — No. 18 Sump Nasogastric Tube

7. TREAT THE BURN WOUND

Rx — Place clean sheet or burn dressing under patient
— Cover patient with a clean sheet
— Wrap painful burn wound (< 10% Body Surface Area) with towels soaked in cool water.

8. PREVENT CHILLING OF PATIENT

Rx — Cover with clean blankets

9. RELIEVE PAIN

Rx — Meperidine or morphine I.V. only

10. TETANUS PROPHYLAXIS

11. TRANSFER TO BURN CENTER

Indications	Magnitu
Children 0-10 yrs.	>10%
Young Adults 11-50 yrs.	>20%
Elderly over 51 yrs.	>10%
Burns of the Face, Hands, Feet, Perineum and Respiratory Tract	
Electrical Burns	

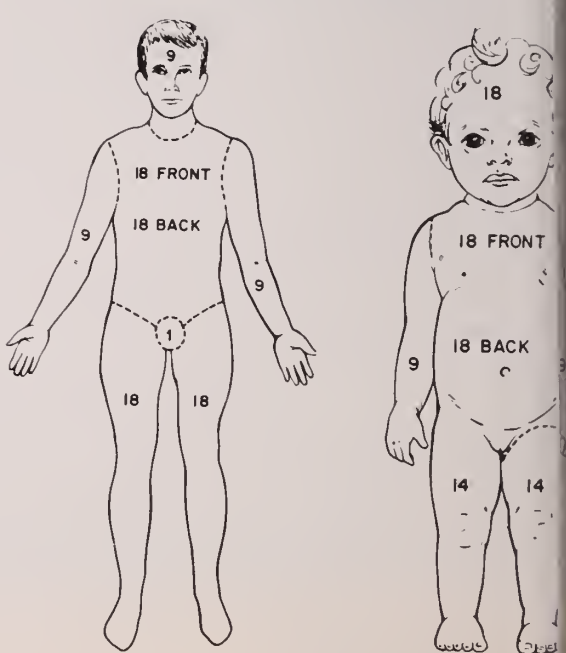
12. EXPEDITE TRANSFER

Air if > 60 miles to Burn Center
Ground if < 60 miles to Burn Center

13. CONTACT APPROPRIATE BURN CENTER BEFORE TRANSFER

Burn Center	Teleph
University of Virginia	804-92
Medical College of Virginia	804-77
Norfolk Medical Center	804-44

RULE OF NINES



Initial Care of the Patient with Major Thermal Injury

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Physicians in Virginia's three Burn Centers have devised a system of management for the emergency treatment of major thermal injury. The advocated guidelines are here discussed.

EMERGENCY MEDICAL personnel in Virginia are treating increasing numbers of critically burned patients. Each year more than 200 lives are lost in this state as a result of burn injury. Today many of these lives might be saved if definitive resuscitation is initiated immediately after injury and the patient rapidly transported to an appropriate specialized burn care center. To this end, the three Burn Centers in Virginia have devised guidelines for the initial care of the patient with a major thermal injury in the emergency department. This treatment has been outlined in poster form for distribution to all emergency departments in the state. The poster is reproduced on the opposite page. The system of management it proposes is here discussed.

Treat Breathing Difficulty.

Swelling of the larynx is usually a late cause of airway obstruction (8-24 hours after burn injury). In this event, nasotracheal intubation is the preferred treatment. If difficulty is encountered in performing intubation, tracheostomy is necessary to maintain a patent airway. The compressive effect of neck eschar may also contribute to the breathing difficulty. In the absence of a tracheostomy, the tight eschar of neck skin accentuates pharyngeal edema and draws the neck into flexion, compressing the pharyngeal airway.[1] A vertical incision from the sternal notch to the chin will relieve this compressive eschar. Escharatomies are performed without local anesthesia.

Respiratory embarrassment may be caused by a constricting eschar of the anterior thorax that limits respiratory excursion. Escharotomy is imperative in this situation. Lateral incisions are made that extend from 2 cm below the coronoid process along the anterior axillary line to 2 cm below the eleventh rib. The top and bottom of the incisions are joined transversely so that a square is formed.[2]

Inhalation of toxic fumes is another cause of breathing difficulty. Respiratory difficulties secondary to toxic fumes may be alleviated by nasotracheal intubation. In the event of continued respiratory embarrassment despite intubation, positive pressure ventilation is indicated. If arterial blood gas measurements are available, they may be used to confirm the necessity for nasotracheal intubation and mechanical ventilatory support. These measurements should be made after the patient breathes room air for at least 3 minutes. The presence of arterial pO_2 that falls below 80 mmHg, combined with the clinical symptoms consistent with respiratory embarrassment, confirm the need for intubation.

Establish Circulation.

Advanced life support measures will be necessary for patients with electrical burns with cardiopulmonary complications (ventricular fibrillation, etc.)

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Perform History and Physical Examination.

Determine the mechanism of burn injury (i.e., thermal, chemical) and estimate the depth of the burn (Table I). The extent of the body surface involved in a burn injury is commonly estimated by the "Rule of Nines". This is accomplished by dividing the major anatomic portions of the body into multiples of 9% of the major body surface area. This is not a precisely accurate method of measuring body surface area, but more exact measurements are so complicated that they have little practical value. In estimating the extent of the burn, individual anatomic areas such as the arm or head must be calculated separately and the total derived from the simple addition of the different areas. The small difference between the surface areas of the adult and the infant reflects the surface area of the infant's head, which is proportionally larger than that of the adult. Before searching for other injuries, remove all clothing and jewelry, especially rings, from the burned limb.

TABLE I

DEPTH OF BURN	APPEARANCE OF SKIN	SENSATION
Full Thickness	White, brown, leathery with clotted vessels	Absent
Partial Thickness	Red with blisters	Present

Prevent Burn Shock.

The cardinal feature of thermal injury is an accumulation of fluid within the injured area and to a lesser degree in unburned skin. Capillaries and venules become immediately permeable to allow large size molecules to leak from the circulation at a rate similar to that of the smaller albumin fractions. Capillary integrity is restored 24 hours later, after which colloids can be administered.[3]

Patients with burns of the following sizes require fluid resuscitation: children 0-10 years > 10%; adults 11-50 years > 20%; elderly > 51 years > 10%. Administer Ringer's Lactate *without* glucose intravenously through a percutaneous plastic catheter inserted in a hand or forearm vein. When an intravenous is started, it is essential to ensure that it is not dislodged during transport and that the calculated amount of fluid is infused. If it is anticipated that the percutaneous catheter may be dislodged in transit, insert a plastic catheter through a cutdown site. A cutdown through burned skin is preferred to starting the intravenous in the leg or using scalp vein needles.

Administer 2 ml of Ringer's Lactate × weight of patient in kilograms (2.2 lbs = 1 kg) × % burn surface area (Rule of Nines) in the first 8 hours *after time of injury*.[3] It is important to emphasize that considerable intravascular fluid may be lost into the burn wound before the patient is transported to the emergency facility. This fluid loss must be calculated and replaced immediately with Ringer's Lactate once the patient with a major burn arrives at the emergency facility. The residual calculated intravenous fluids are administered over the remaining part of the 8-hour time interval.

The adequacy of fluid resuscitation is determined by monitoring urine output every hour via Foley catheter. Urine output should be maintained at 40 ml/hr for adults and 10-15 ml/hr for children.

Palpate Pulses in Circumferentially Burned Limb.

Full thickness burned skin has a leathery consistency which resists stretch. When edema develops beneath a circumferentially burned extremity, the leathery skin exerts a tourniquet-like effect on the extremity embarrassing its circulation. Progressive loss of sensation or impaired joint proprioception are reliable clinical signs of vascular insufficiency.[4] If this complication seems likely, escharotomy through the burnt skin can restore the embarrassed circulation. Anteriolateral and anteriomedial incisions are carried over involved joints, avoiding the superficial vessels whenever possible.

Treat Ileus.

In patients receiving fluid resuscitation, a No. 18 nasogastric (sump) tube should be inserted. The tube should be attached to continuous suction (40 mmHg).

Care of Burn Wound.

A clean sheet or nonadherent burn dressing should be placed under the patient. The patient should be kept warm by covering him first with a clean sheet, followed by clean blankets. Intact blisters should be left alone. The burn wound should not be contacted by either ice water, ice or ointments.

Relieve Pain.

The requirement for sedation is inversely proportional to the depth of the burn. The intrinsic sensory nerve endings of full thickness burns are destroyed, leaving them painless. In contrast, the partial thickness burns have intact nerve endings and are painful. In patients with partial thickness burns, analgesia can provide considerable relief. Once the patient's condition has stabilized, narcotics may be administered by an intravenous route over a 4- to 5-minute period to assure predictable action. Narcotics should be given cautiously since they can depress respiratory and cardiac function.

Tetanus Prophylaxis.

Dead burn tissue supports the growth of *Clostridium tetani.* For that reason, tetanus prophylaxis is essential in all burn patients, but may be deferred until the patient reaches the Burn Center[5] (Table II).

TABLE II

GUIDE TO TETANUS PROPHYLAXIS IN BURN PATIENTS

History of Tetanus Immunization (Doses)	BURN WOUNDS: Tetanus and Diptheria Toxoid (Adult Type)	BURN WOUNDS: Tetanus Immune Globulin (Human)
Uncertain	Yes	Yes
0-1	Yes	Yes
2	Yes	No[1]
3 or more	No[2]	No

[1]Unless burn more than 24 hours old
[2]Unless more than 5 years since last dose

When tetanus toxoid and globulin are given concurrently, separate syringes and separate sites should be used.

Transfer to Burn Center.

The extent of the total body burn and the age of the patient serve in part as guidelines for the selection of a treatment facility to which the patient is sent (Table II). The mortality of the burn patient is directly related to the size of the burn. The young adult (10-50 yrs of age) tolerates a thermal injury somewhat better than any other age group.[6] The 50+ age group shows the least tolerance for burn injury and must be given special consideration. Since children with major thermal injuries frequently fail to respond normally to the initial burn therapy, their refractoriness to care necessitates treatment in a specialty burn care center.

Even though the depth of the burn exerts considerable influence on patient outcome, its influence on patient triage is often minimal since it is difficult to determine accurately soon after injury. Assessment of the depth of injury can usually be accomplished 2-4 days postburn.

The extent of the burn, in terms of burn surface area, is meaningless as an index of severity in burns in special locations. Burns of the face, neck, hands, feet or genitalia are serious burns that necessitate treatment at a specialty burn center. Fractures associated with thermal injury also deserve special care and the presence of a burn necessitates modification of fracture management.[7]

The mechanism of burn injury is another important triage consideration. An electrical burn injury is a case in point; it demands management in a specialty burn center.[8] This injury is unique to the field of burn care in that underlying tissue destruction is usually considerably more extensive than the skin injury. For that reason, the quantity of fluid sequestered in areas of electrical injury is often grossly underestimated. In addition, electrical injuries often result in multisystem derangement. Bone destruction, nervous system injury, eye damage, renal dysfunction and cardio-respiratory complications are frequently encountered. The sequelae of electrical injury may occur as long as 1-3 years after injury, emphasizing the delayed effects of the injury.

Expedite Transfer.

When the emergency department facility is less than 60 miles from the specialty burn center, the patient is transported by ambulance. Air transport utilizing a commercial airline is used when the distance between the burn center and the emergency department is greater than 60 miles.

Notify Burn Center Before Transfer.

Three burn centers in Virginia are prepared to care for the severely burned patient. The telephone number of each center is listed on the burn poster. The referring physician should contact the personnel at one of the burn centers prior to transfer of the patient; this warning is essential to assure that the patient's condition is stable enough to permit transfer. A contraindication to transfer is, of course, the patient's failure to respond to a well-planned resuscitative program as a result of other injuries that demand immediate attention. Prior to transfer, the physician completes a transfer medical record which accompanies the patient en route to the Burn Center.

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Brain Revascularization for Stroke Patients

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A case of temporal artery anastomosis is presented to illustrate a discussion of the procedure's value in increasing cerebral blood flow and preventing stroke.

BRAIN REVASCULARIZATION is a most promising new development in the surgical therapy for stroke. Stroke is the third leading cause of suffering and death in this country. Five hundred thousand Americans are afflicted by stroke each year and of these, 200,000 die. Two million Americans remain disabled and unemployed because of stroke. Two-thirds of stroke patients are under 65. Stroke is not a disease of old age.

The occlusion in arteries is often localized; if the obstruction can be bypassed, then blood can be delivered to the ischemic areas of the brain distal to the block. Thus the aim of this surgery is to *prevent* a disabling stroke.

As early as 1951, Dr. C. Miller Fisher foresaw that a bypass operation was feasible. It remained for Drs. Donaghy and Yasargil, in 1967, to translate this concept into reality. Since then, superficial temporal artery to middle-cerebral artery anastomosis has been performed worldwide nearly 400 times by 25 neurosurgeons.[1] The following is the report of such a case.

Case Report

A 57-year-old right-handed male had diplopia and dyslexia and dyscalculia which lasted one week in January, 1975. On August 14, 1975, he fainted and thereafter had a left hemiparesis for 24 hours. About every other day, he had transient dizziness and numbness of the left hand. His hypertension and mild diabetes were well controlled.

The neurological examination showed only hypalgesia to pin over the right forehead and cheek and slight unsteadiness on quick turns. The retinal artery pressures were decreased on the left. Skull x-ray, brain scan and EEG were normal. A retrograde femoral arteriogram showed complete occlusion of the left internal carotid near the bifurcation (Fig. 1).

On September 18, 1975, the left superficial temporal artery was dissected from the galeal bed and introduced onto the surface of the brain through a temporal craniectomy and there anastomosed to a cortical branch of the left middle cerebral artery using 10-0 suture. The operating microscope was employed at magnification 25 and 40. Each vessel measured about 1.5 mm in diameter. He had garbled speech for several days postoperatively, which cleared completely. His neurological examination at the time of discharge was normal. The left superficial temporal artery had a palpable pulse at the anastomosis site. He returned to work on October 4, 1975 (Fig. 2), as the manager of a real estate office. The patient has had no further transient ischemic attacks since surgery and had a normal neurologic examination one year later.

Discussion

Most patients with extracranial or intracranial occlusive arterial disease have many preliminary warn-

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Fig. 1 (left). Left carotid angiogram. Lower arrow indicates complete occlusion of left internal carotid artery. Double arrows indicate parietal branch of the superficial temporal artery used to bypass the occlusion.

Fig. 2 (above). Postoperative view. Arrow indicates approximate site of the anastomosis.

ings before a major stroke occurs. These warnings consist of transient ischemic attacks lasting seconds to minutes. Approximately 25% of patients with TIA's develop a major stroke within 44 months.[2] In general, patients with transient attacks of motor, sensory or speech deficits or patients with impaired mentation, syncopal attacks, transient or progressive visual loss and/or ataxia and postural vertigo are candidates for this procedure.[3] Angiography must be correlated with the history and clinical findings. Occlusion of the extracranial portion of the internal carotid artery, stenosis or occlusion of the middle cerebral artery, provide the basis for the bypass procedure.

The risk of the procedure is quite small. The early clinical results are very encouraging. In Austin's series of 35 patients, he achieved "excellent" (0-3 TIA's postoperatively) and "good" (3-10 TIA's) in 83% of the patients. No patient had a stroke after surgery in followup of 1½ years. It is believed to improve these patients because measurements have shown that the graft contributes 20-30 cc per minute of additional cerebral blood flow to the ischemic area. The graft also enlarges with time,[4] and can contribute as much as 60 to 75 cc per minute. For a marginally constituted cerebral blood flow this extra amount can mean the difference between health or stroke.

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Variables in Controlled Studies of Diabetic Retinopathy

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A new classification of diabetic retinopathy is proposed for easier assessment of therapeutic results. Evaluation of treatment goals in relation to the effectiveness of therapy, especially in the application of photocoagulation, is discussed.

CONTROLLED STUDIES in diabetic retinopathy, both in following the natural course of the disease and in evaluating forms of therapy, have been complicated by two variables: spontaneous remissions, which are random in occurrence and known to occur at all stages of the disease; and the use of visual acuity as a criterion for statistical evaluation, disregarding the correlations of variables of maculopathy with the degree of existing background retinal pathology.

If it is possible in some manner to separate the remitters from the nonremitters and if it is possible to have a better criterion than visual acuity for evaluating natural course and therapeutic effects, one will then be able to devise more controlled studies relatively free of these variables and their relationships. A different approach in classifying the relationship of the degree of diabetic retinopathy to systemic disease and to the variable expression of the retinal pathology is suggested. The two new ratios believed to reduce the marked variables in the study of diabetics are to some degree arbitrary and subjective; however, they should add to prognostic considerations.

Separation of the "remitters" from "nonremitters" is based on the assumption that some patients show periodic spontaneous remissions while others do not, during the natural disease course. The latter will progress in a definite unrelenting fashion from microaneurysms to exudates, to neovascularization, hemorrhage, gliosis, vitreal traction and retinal detachment with blindness. In remitters, exacerbations do not exceed remissions; in nonremitters, exacerbations regularly exceed remissions in a progressive fashion.

If one accepts these two assumptions, then a third one follows, namely, that the nonremitters will have a more rapid disease course than the remitters. This recognition that there are definitely remitters and nonremitters is strongly suggested in Caird's discussion of proliferative diabetic retinopathy,[1] in which he states, "If blindness does not occur in a year, it is unlikely to do so in the next few years; perhaps a stable state is reached." Thus, rapidity of progress can be used as one criterion to separate the two groups by application of the ratio of disease duration to the degree of diabetic retinopathy (DD:DR ratio). The nonremitters could then be studied with the variables of spontaneous remission reduced to a minimum.

From a general average of studies conducted by many investigators, the DD:DR ratio average would be approximately 15:1 or 15, i.e., it takes an average of 15 years for a patient with diabetus mellitus to develop a grade 1 retinopathy. This could include remitters and nonremitters, if there is no effort made to separate them. However, in clinical screening patients are often found with a disease duration of only eight to ten years having already a grade 3 to grade 4 retinopathy. These patients then would have,

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for instance, DD:DR ratios of 8 (years): (degree) 3 or 2.67 and 10:4 or 2.5 respectively, and could therefore be classified as nonremitters. Conversely, patients may be seen with disease duration of 30 years and only a grade 1 to grade 2 retinopathy. In these cases the DD:DR ratio would be 30:1 or 30 and 30:2 or 15 respectively. Since an average of previous studies would give a DD:DR ratio of 15, it can be arbitrarily stated that DD:DR ratios of less than ten are probably nonremitters. Thus, patients selected for controlled studies should have DD:DR ratios of ten or less, depending on the judgment of the individual investigator. If patients are selected in this manner for photocoagulation studies, drug evaluations or natural course studies, it seems permissible to assume that the variables of spontaneous remission have been to a great extent eliminated.

The application of the DD:DR ratio is based on the following grades of general retinopathy:

Grade 1, microaneurysms and soft exudates;
Grade 2, dot and blot intraretinal hemorrhages, microaneurysms and hard exudates
Grade 3, neovascularization (in addition to above);
Grade 4, vasoproliferation, extensive hemorrhages and gliosis.

The classification deals only with general background retinopathy and of necessity does not consider involvement of the macula per se, which we have chosen to classify separately in an effort to define more clearly the acuity variable.

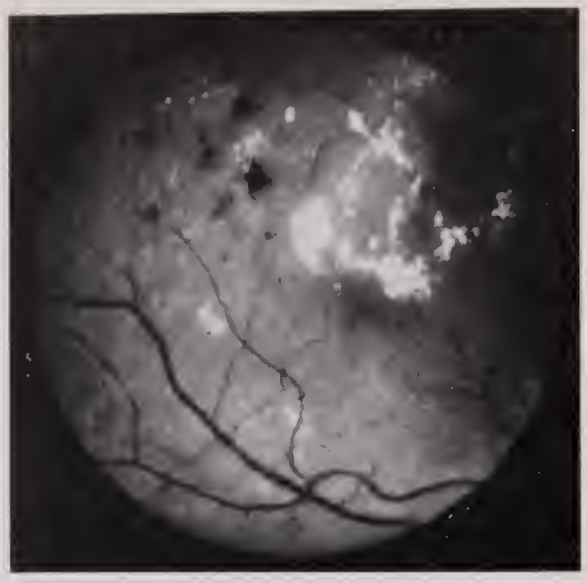


Fig. 1. Generalized "background" retinopathy. Macula little involved. Visual acuity 20/25.

Patients with high DD:DR ratios can be carefully screened by history as to their use of drugs, control of diabetes and other factors which might explain why they are remitters. In this way some knowledge can be gained from these "nature-made" experiments referred to by Duane.[2] We have used this ratio to screen patients regarding drug use and have compared the findings of low DD:DR ratios. The findings were

A New Vocabulary . . .

This article uses new terms which may define more appropriately the ocular fundus pathology in diabetes mellitus. They are here described.

Remitters: Patients whose natural course of retinopathy undergoes periods of remission. The reasons for remission are as yet unknown.

Nonremitters: Patients whose natural course of retinopathy has been progressing without remission.

DR:DM ratio: A ratio of diabetic retinal pathology involving the entire retina except the macular region (background retinopathy) to the degree of maculopathy based on a separate classification of both. This is important because in a large percentage of cases visual acuity does not necessarily correlate with the total degree of pathology.

DD:DR ratio: A ratio of disease duration to the degree of retinopathy which can be used to separate remitters from nonremitters. This is useful in removing the variable of spontaneous remission. This ratio also is important in taking history on patients with a high DD:DR ratio (remitters) and by careful screening to ascertain the factors that might be responsible for remission.

DD:DM ratio: A ratio which correlates disease duration and severity of maculopathy similar to the DD:DR ratio for defining the background retinopathy disregarded in the DD:DM ratio.

Visual Acuity Correlators: Those patients in whom the DD:DR ratio correlates with DD:DM ratio.

Visual Acuity Noncorrelators: Patients in whom the DD:DR ratio is usually high and the DD:DM ratio low or vice versa.

Correlators and noncorrelators should therefore be treated separately in clinical investigations primarily relating kind of therapeutic approach to results on visual acuity changes.



Fig. 2. Maculopathy with visual acuity decreased to 20/200 but relative little involvement of remaining retina.

significantly different from those of patients without treatment.[3]

Not discriminating between background retinopathy and maculopathy is unfortunate and complicates the use of visual acuity as a criterion in the effectiveness of therapy or natural course evaluations. Clinically, it has been observed that maculopathy may be severe in instances of otherwise minimal generalized retinopathy; conversely, maculopathy may be minimal in instances of severe general background retinopathy. The classic grading of diabetic retinopathy of grade 1 to grade 4 does not separate maculopathy from general fundus pathology as stated above. This includes the O'Hare or Airlie classifications.

In reviewing the literature, there is no consideration given to visual acuity deficits due to maculopathy separately from visual acuity losses occurring with general retinopathy and the secondary media changes of hemorrhages and/or gliosis. Therefore, the percentage of acuity deficits secondary to macular changes only is difficult to ascertain. Macular changes in general are the cause of visual acuity deficits in a majority of cases, as illustrated by the study of Myers et al,[4] in which the causes of visual acuity loss in 200 eyes followed over a period of six months were as follows:

1) severe vitreal hemorrhage, 66 (33%);
2) macular detachment, 47 (23%);
3) macular edema, 35 (17.5%);
4) tension lines in the macula, 13 (6.5%);
5) macular exudates, 9 (4.5%);
6) macular pigment, 9 (4.5%).

In this list macular detachment and retinal tension lines are usually secondary to general gliotic processes; however, macular edema, macular exudates and macular pigment abnormalities, representing a total of 26.5%, can occur without any correlation with the degree of general background retinopathy. This fact cannot be ignored if the variables of visual acuity changes as criteria of evaluation are to be eliminated.

Caird stated,[1] "The chances of blindness were three to five times greater in eyes with visual impairment than in those with good vision." These were obviously patients with maculopathy. Caird also states, "In background retinopathy. . . . . .prognosis for vision is good over several years." He separates background from proliferative changes but does not separate maculopathy from general retinopathy. The differences that exist concerning the use of visual acuity as a criterion is aptly illustrated by the following. Davis[4] noted, "The use of visual acuity as a magic criterion for judging results seems quite satisfactory"; whereas Thornfeldt[5] states, "Visual acuity is extremely misleading in that it is dependent upon so many factors. . . .and I believe that it is not a valid means of expression." Beetham's opinion[6] is, "I personally feel that the record of the visual acuity does not reflect the picture of retinopathy, and only pertains to a small area." These opposing viewpoints regarding the use of visual acuity as a criterion and the opinions that any visual acuity loss presents a severer prognosis than could be ascribed to the degree of a generalized retinopathy, can thus be misleading.

Therefore, it is proposed to apply a classification for maculopathy independent form background retinopathy as follows:

Grade 1, microaneurysms in the foveo-macular area;
Grade 2, macular edema;
Grade 3, macular hard exudates;
Grade 4, macular hemorrhage, tension lines or detachment, and absence of demonstrable capillary blood supply to the macula as noted on fluorescein angiography.

The variations of general background retinopathy and maculopathy may, among other factors, be physiologically related to the differing blood supplies. Maculopathy directly affects visual acuity, while background general retinopathy may be severe without doing so and then perhaps only indirectly through such changes as premacular hemorrhage, gliosis, vitreal hemorrhage or vitreal traction bands. It is thus readily concluded that visual acuity can be used as a guide for controlled studies only if the

DD:DM ratio correlates in general with the DD:DR ratio, or if patients with maculopathy and those without maculopathy are placed in separate groups. For example, if a patient with a grade 2 general background retinopathy and a grade 4 maculopathy is used in a controlled study, there may be a marked ophthalmoscopic observable improvement in the way of peripheral retinal findings but slight if any improvement in visual acuity. Conversely, a patient with grade 4 general retinopathy and a grade 1 maculopathy may be subjected to a form of therapy which produces little if any general retinal improvement but over a long period of time may show a stable acuity, which may lead to a false conclusion concerning the effectiveness of therapy.

Patients with low DD:DR ratios, therefore, should be placed in separate study groups, because maculopathy processes are often permanent in their degree of destruction, particularly in instances of hemorrhages or massive hard exudates in the foveal or perifoveal areas. Perhaps only macular edema and/or hemorrhages can be expected to regress significantly. Since direct macular processes may so often be disproportionately destructive, patients with a low DD:DM ratio cannot reasonably be included in studies directed at therapy of general retinopathy; and statistical findings based on acuity in these instances would be of little value, since in cases with increasing macular ischemia, photocoagulation is of no value if improvement of macular function is the goal of the therapy.

A third variable in studies of diabetic retinopathy is the difference in goals to be accomplished by the administered therapy. This variable of course is set by the individual investigator, by his predetermination of what he hopes to accomplish. There are primarily three possible goals, namely, cure, regression or stabilization of the disease process. Efforts to obtain cures prove mostly to be very disappointing and perhaps are not realistic in many instances, certainly where fluoresceine angiography proves progressive deficiency of capillary blood supply to the macula. Attempts to obtain regression are also unrealistic if it is obvious that the character of tissue changes are not likely to be reversible. Stabilization can be satisfactory and a very realistic goal, for it is readily apparent that as far as the patient is concerned, arrest of retinopathy at a visual acuity of 20/60 or even 20/200 is definitely preferable to a progressive deterioration to light perception or no light perception. Perhaps studies directed at improving visual acuity are desirable, although it might be more realistic to direct studies toward maintaining existing visual acuity. These different goals should be clearly recognized and delineated by each investigator undertaking a controlled study.



Fig. 3. Diabetic retinopathy involving both general retina and macular area with vascular and glial proliferation.

Conclusions

Controlled studies in diabetic retinopathy cannot be successfully accomplished unless the variables of spontaneous remissions and acuity noncorrelation can be eliminated.

The DD:DR ratio (disease duration versus the grade of retinopathy excluding the macula) is proposed as a reasonable method of separating remitters and nonremitters.

DD:DM ratio (disease duration versus the grade of maculopathy) is proposed as a reasonable method of separating acuity correlators and acuity non correlators.

DR:DM ratio (diabetic background retinopathy versus maculopathy) is proposed to classify maculopathy separately from general background retinopathy, since maculopathy is directly related to acuity, while background retinopathy is not necessarily.

Goals of therapy should clearly be predetermined by each investigator as to the result expected, such as cure, regression or stabilization.

The concepts of remitters and nonremitters, acuity correlators and noncorrelators, the DD:DR and DD:DM ratios, and a separate classification of maculopathy, all these are different concepts, presented for discussion to better relate results, although possibly achieved with different therapeutic means.

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New Edition for Dr. Geeraets' Book

Dr. Walter J. Geeraets, coauthor of the preceding article, is the author of a distinguished textbook and reference, *Ocular Syndromes,* published by Lea & Febiger, Philadelphia. A handsome third edition of this work, with greatly expanded entries and new index, has recently come off the presses. The Editors have placed a copy of it for review, and that review is soon to be published in these pages.

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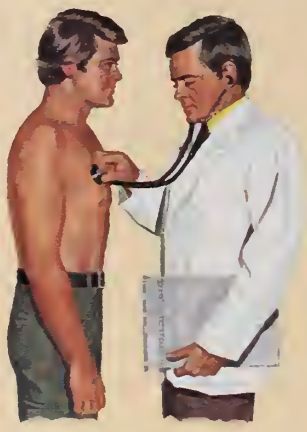
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Narrowing down pneumonias

Upjohn

Bacterial or nonbacterial?

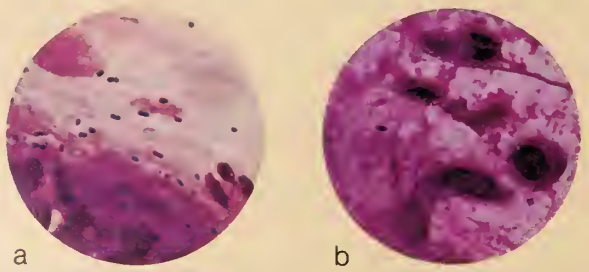
In the early stages of mild to moderate pneumonia, it is often difficult to reach an accurate bacteriologic diagnosis. A tentative differentiation may be made on history-taking, physical examination, CBC with differential analysis, and microscopic study of the sputum smear. Specimens should be obtained for culture and sensitivity testing, but when a bacterial pneumonia is diagnosed, therapy is often instituted before the etiological agent is positively identified.



Bacterial pneumonias may have a sudden onset with a shaking chill, rapid development of fever, pleuritic pain, and cough productive of rust-colored sputum. The Gram-stained sputum smear generally shows polymorphonuclear neutrophils as well as a predominance of the causative organisms. These are likely to be *Streptococcus pneumoniae,* still by far the most frequently encountered agent in bacterial pneumonia.[1] The CBC reveals marked leukocytosis with a shift to the left.

In *nonbacterial pneumonias*—mycoplasmal or viral—classical symptoms tend to develop more slowly, with myalgia, lassitude, and headache predominating. Sputum production is usually scanty, and the sputum smear is relatively uninformative, showing gram-positive cocci and other organisms which are part of the normal pharyngeal flora. The leukocyte count is normal or slightly elevated.

Direct Gram-stained sputum smears. (a) Pneumococcal pneumonia—note abundant polymorphonuclear leukocytes, as well as gram-positive diplococci. (b) Nonspecific—consistent with viral or mycoplasmal pneumonia. Note large mononuclear cell, as well as a few polymorphs and mixed bacterial flora (pharyngeal contaminants).



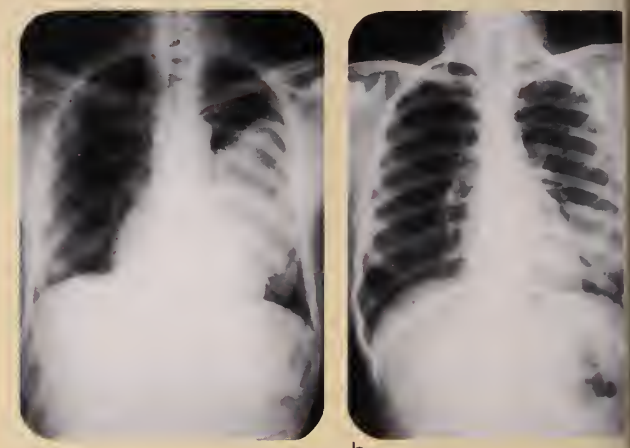
a b

Mycoplasmal or viral?

Differentiation between mycoplasmal and viral pneumonias may be impossible in the acute stage.

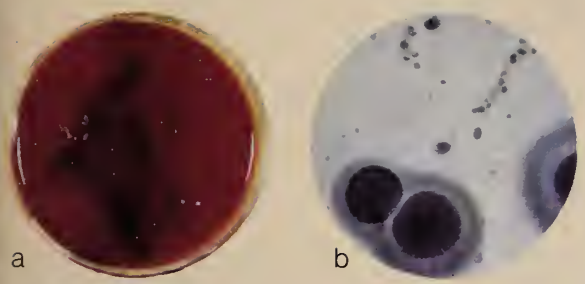
Serologic testing and culture methods for *Mycoplasma pneumoniae* are complex and time-consuming, taking as long as two weeks after obtaining samples. The sensitivity and specificity of the test for cold agglutinins have been questioned. The complement-fixing antibody test may reflect previous infection. Furthermore, facilities for culturing *M. pneumoniae* are not widely available.[3]

If treatment is to be initiated, therefore, it may be necessary to start on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.[1-3] In reaching such a diagnosis, the physician relies on clinical judgment, considering such factors as the age of the patient and the history of exposure. For example, *Mycoplasma pneumoniae* is considered the most common cause of pneumonia among ambulatory patients aged 20 to 35.[1]



a b

Chest x-rays of patients with (a) pneumococcal pneumonia—classically heavy, extensive infiltration of left lung; (b) mycoplasmal pneumonia—mild infiltrate confined to left lower lobe. Roentgenography usually does not help in differential diagnosis, since both types of pneumonias may present with a wide spectrum of x-ray as well as clinical findings.



a b

(a) Distinct mucoid colonies of type 3 pneumococci *(Streptococcus pneumoniae)* on sheep blood agar showing greenish discoloration (alpha-hemolysis) of medium. (b) Typical "fried-egg" colonies of *Mycoplasma pneumoniae* consisting of dense central core with lighter periphery. Cultural and serologic methods for detecting *M. pneumoniae* are complex, time-consuming, and not widely available.

Expectant therapy

n the patient with a presumptive diagnosis of ycoplasmal pneumonia or bacterial pneumonia, it ay be desirable to initiate antibiotic therapy before ulture and sensitivity results are available.

A course of erythromycin or tetracycline is onsidered effective in the treatment of mycoplasmal neumonia to help speed the clearing of infiltrate and horten the duration of symptoms.[1,3] In pneumococcal neumonia, erythromycin is an effective alternative to enicillin, the drug of choice. A recent report, based n data from 200 hospitals of 100 beds or more, found 8% of *S. pneumoniae* sensitive *in vitro* to rythromycin.[4]

Among these therapeutic agents, only rythromycin provides effective coverage of both *Mycoplasma pneumoniae* and *S. pneumoniae*. The enicillins are not effective against *Mycoplasma*, and *S. pneumoniae* has shown a relatively high incidence f resistance to tetracycline.

When erythromycin is selected for therapy, E-Mycin (erythromycin enteric-coated tablets, Upjohn) s a good choice. E-Mycin is administered and bsorbed as active erythromycin base, and may be aken q.i.d., q 6h, or b.i.d., immediately after meals or etween meals. Thus, patients can use mealtimes to elp them remember their medication. The enteric oating on E-Mycin tablets helps ensure efficient bsorption in the intestinal tract, and bioavailability tudies show that E-Mycin can be expected to roduce predictable, acceptable blood levels. The ow cost of E-Mycin helps assure economical therapy.

E-Mycin rarely causes serious side effects and is ot associated with liver toxicity.* The most frequent ide effects are upper gastrointestinal, such as bdominal cramping and discomfort, and are dose-elated. Nausea, vomiting, and diarrhea occur nfrequently with usual oral doses. Serious allergic eactions, including anaphylaxis, have rarely been eported.

*Use cautiously in patients with severe liver impairment.

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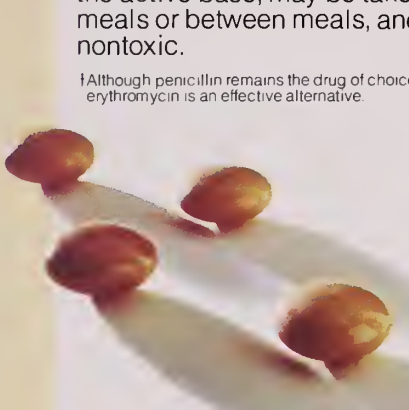
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Summary

Because pneumonias may be difficult to differentiate at the outset, treatment is often initiated before a causal diagnosis is made. However, readily available diagnostic criteria occasionally allow early differentiation between bacterial and nonbacterial pneumonias. When the diagnosis appears to be nonbacterial pneumonia, further differentiation between mycoplasmal pneumonia and viral pneumonia is more complex and time-consuming. Therefore, therapy is often initiated on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.

Erythromycin is an effective antibiotic against *Mycoplasma pneumoniae*, *Streptococcus pneumoniae*,† and *Streptococcus pyogenes*.† E-Mycin (erythromycin enteric-coated tablets, Upjohn) is administered and well absorbed as the active base, may be taken immediately after meals or between meals, and is essentially nontoxic.

†Although penicillin remains the drug of choice against these organisms, erythromycin is an effective alternative.



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*Mild to moderately severe, due to susceptible organisms

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Wide-ranging usefulness in pneumonia*

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Alpha-hemolytic streptococci (viridans group): Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery where the organisms likely to lead to bacteremia are gram-negative bacilli or the enterococcus group of streptococci.)
Staphylococcus aureus: Acute infections of skin and soft tissue of mild to moderate severity. Resistance may develop during treatment.
Diplococcus pneumoniae: Upper respiratory tract infections (eg, otitis media, pharyngitis) and lower respiratory tract infections (eg, pneumonia) of mild to moderate degree.
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Corynebacterium diphtheriae and *Corynebacterium minutissimum:* As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.
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Listeria monocytogenes: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.

Precautions: Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.

Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

Treatment of overdosage: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdosage should be handled in the usual manner—that is, by the administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug, in addition to all needed supportive measures.

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Brain Abscess: Diagnostic and Therapeutic Problems

Terry P. Yarbrough, MD, and Frank Clare, MD, *Portsmouth, Virginia*

Two cases of brain abscess encountered in a community hospital are presented, illustrating the imperative of early diagnosis and therapy.

RECENT REVIEWS of brain abscess have emphasized the continued high mortality despite advances in diagnostic procedures, available antimicrobial therapy and neurosurgical techniques. Two cases encountered in a community hospital illustrate the problems associated with diagnosis and therapy.

Case Reports

Case 1.

A 16-year-old, right-handed female was first admitted on 1-11-73 with a sudden onset of severe headache followed by a generalized seizure. Neurologic examination on admission was unremarkable. Studies included a normal brain scan and skull x-rays. A lumbar puncture was normal except for the cell count, which revealed six lymphocytes. An electroencephalogram showed abnormal slow activity, more so in the left frontal region. The hemogram revealed an elevated white blood cell count of 14,000 with 78 neutrophils. The possibility of encephalitis was considered; however, she became asymptomatic and was discharged one week later.

She was readmitted after five days because of recurrent severe frontal headaches and hysterical behavior. Reexamination revealed intermittent crying and emotional instability but was otherwise unremarkable. Observation over a five-day period revealed progressive lethargy followed by a left sixth cranial nerve palsy and early papilledema of the left optic disc. Her temperature was normal. Repeat blood studies were normal except sedimentation rate of 27 by Cutler method. A neurosurgical consultation was obtained. A left carotid arteriogram was performed and revealed marked displacement of the left anterior cerebral artery with evidence of a non-vascular left frontal mass (Fig. 1). Eighty-five ml of fecal odoriferous pus was removed by needle aspiration through a left frontal burr hole. A catheter drain was inserted and irrigated with penicillin and streptomycin. Cultures grew anaerobic streptococcus and bacteroides. Therapy consisted of aqueous penicillin G24 million units daily and chloramphenicol 2.0 grams daily for five weeks. The arteriogram was repeated on 3-8-73 and showed return to normal. She was discharged with no neurologic residual except for partial left sixth cranial nerve palsy. Examination in September 1975 showed no residual. The patient was asymptomatic except for one seizure three months before when she stopped taking diphenylhydantoin (Dilantin) on her own initiative.

Case 2.

A 17-year-old, right-handed white male was admitted on 2-8-73 with a five-week history of upper respiratory infection followed by a left retroorbital pain. He was treated as an outpatient by an otolaryngologist for maxillary and frontal sinusitis with antibiotics and sinus irrigation. Two weeks prior to admission he developed intermittent nausea and vomiting and persistent left retroorbital headache. Admission physical examination including neurologic examination was normal except for some drowsiness. White blood cell count was elevated to 14,000 with 76% neutrophils. Sedimentation rate, Cutler method, was 23. Sinus x-rays revealed pansinusitis; skull x-rays and upper gastrointestinal series were normal. During the initial 72 hours he continued with intermittent nausea and vomiting. Lethargy improved initially but suddenly he deteriorated neurologically with increasing confusion, disorientation and lethargy associated with the development of left pupillary dilation,

Address correspondence to Dr. Yarbrough at 3300 High Street, Portsmouth VA 23707.

Submitted 1-22-76.



Fig. 1.



Fig. 2.

bilateral papilledema, mild right hemiparesis and bilateral Babinski response. Emergency left carotid arteriogram revealed a large avascular left frontal mass with displacement of the left anterior cerebral artery to the right of the midline (Fig. 2). Aspiration of 60 ml of nonodoriferous pus from a left frontal lobe abscess was performed. A catheter was inserted and irrigated with penicillin and streptomycin. Cultures grew anaerobic stretococcus and staphlococcus epidermidis. Postoperative management consisted of penicillin 15 million units daily, streptomycin one gram daily, and chloramphenicol 3 grams daily. He continued with intermittent vomiting and lethargy; he developed a right hemiparesis, necessitating repeat carotid arteriography and repeat needle aspiration. On 3-27-73 complete excision was carried out of a large encapsulated left frontal lobe abscess. This necessitated a partial lobectomy. Gradual improvement followed but convalescence was slow. He was discharged six weeks later with no significant sequelae other than a right hemiparesis. Examination in November 1975 revealed the only significant deficit to be some slight unsteadiness of gait. He had no seizures and was working full time for the city.

Discussion

Both of these cases illustrate the typical clinical presentation of brain abscess. Headache, nausea, vomiting, lethargy and seizures are among the most common presenting features reported.[1] Examination frequently reveals papilledema and a focal neurologic deficit. If the lesion is in the hemisphere it often presents as a mild hemiparesis. Photophobia was exhibited in both of these patients. While this is not uncommon in meningitis or subarachnoid hemorrhage, it rarely occurs in neoplasm.

Patients with brain abscess may often exhibit normal temperature curves and normal WBC patterns. They do, however, have an elevated sedimentation rate. One of the authors has been interested in brain abscesses for the past 30 years. During this time he has seen no brain abscess patient with a normal sedimentation rate. It is estimated that this includes approximately 50 such patients. Thus, the only virtually constant peripheral blood picture is one of an elevated sedimentation rate.[2] It has been found that the Cutler method seems to give a rough quantitative index on the course of the disease.

A primary source of infection in patients with brain abscesses can often be identified, most commonly an extension from chronic otic or paranasal sinus infection, as in Case 2. Other sources include

oral or pulmonary infection, sepsis, congenital heart disease, intracranial trauma, or surgery.[3]

Noninvasive diagnostic studies of value include the electroencephalogram and brain scan; interestingly, both cases reported above had normal brain scans. The new technique of computerized axial tomography, when available, is certainly of value in localization. The hazards of lumbar puncture in suspected cases of brain abscess are well documented; not only is it unreliable for diagnosis, but there is a significantly increased risk of brain herniation following the procedure.[2,4,5] While ventriculography is occasionally used for localization, cerebral arteriography remains the primary diagnostic study for accurate evaluation, as demonstrated in both cases described here.

Although most bacteriology studies indicate staphlococci and streptococci as the most frequent pathogens involved, numerous factors, including the primary source of infection, age and immune status of the patient and prior use of antibiotics, may determine the bacterial flora.[1] With the development of improved transport and culture techniques for anaerobes, the importance of these organisms in brain abscess has been recognized.[6] Bacteroides and anaerobic or microaerophilic streptococci appear to be the most frequent isolates. Thus, initial systemic antibiotic therapy should consist of penicillin G 20-30 million units per day and chloramphenicol 2 grams per day. In addition an aminoglycoside is recommended by some authorities because of the possibility of enterococcal infection.[1] Antiobiotic therapy should probably be continued for four weeks or longer. As pointed out by Morgan et al, the lack of availability of thorium dioxide colloidal suspension (Thorotrast) for use in the abscess itself is to be deplored. It would have been very helpful in Case 2.

Surgical therapy consists of either drainage or excision. If drainage is performed, a catheter is inserted into the abscess cavity and utilized for intermittent aspiration and irrigation for several days. Total excision is frequently preferable as in Case 2, where persistent mass effects of the abscess were apparent.

Summary

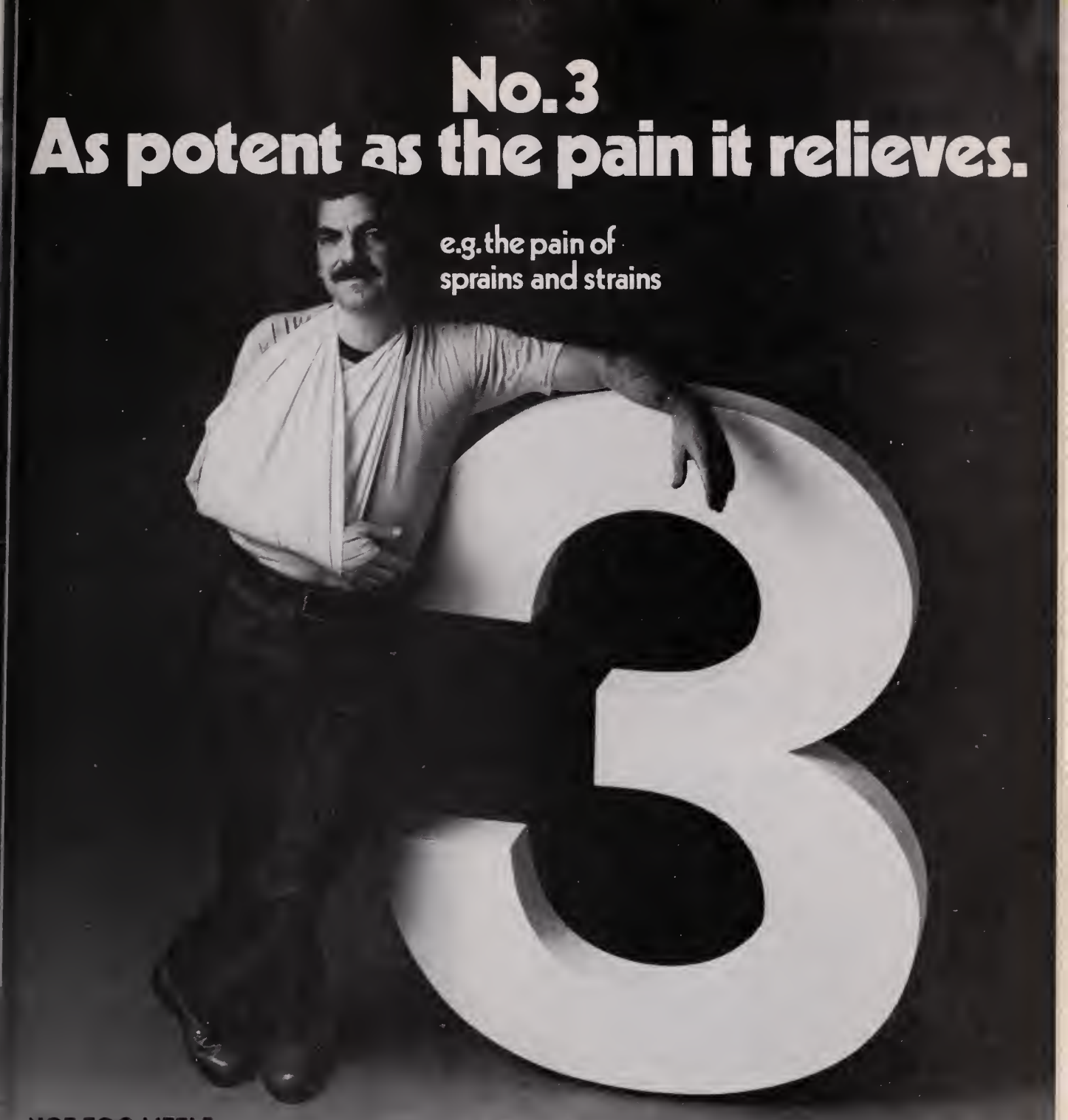
Two patients approximately the same age were admitted to the hospital within two weeks of each other with left frontal lobe abscesses. The treatment of each had to be modified considerably due to the course of the disease process. Fortunately, the results 20 months later were both favorable.

It should be reemphasized that despite improvements in diagnostic techniques and medical and surgical therapy, mortality rates of brain abscess remain 30-60%. Unfortunately this is comparable to those of Macewen in Scotland in 1893. Reduction in mortality and morbidity from brain abscess will occur only when the diagnosis is considered early, so that adequate therapy may begin before marked deterioration in neurologic status has occurred.

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Histoplasma Mediastinal Granuloma In an Asymptomatic Child

P. M. Fitzer, MD, *Newport News, Virginia*

A lesion rarely seen in asymptomatic children is revealed after discovery during routine chest radiography of a right mediastinal mass with stippled calcification.

MEDIASTINAL GRANULOMA, a caseous or fibrocaseous mass, is an uncommon lesion of childhood[1]. Most documented cases in children have produced symptoms, ranging from cough to tracheal obstruction. This report describes an incidentally discovered mediastinal granuloma in an asymptomatic child.

Case Report

An 8-year-old girl was admitted for routine tonsilectomy and adenoidectomy. Aside from recurrent episodes of otitis media, she had been in good health. There was no recent history of cough, dysphagia or fever; parents and siblings were well. There had been no recent travel outside Virginia. Physical examination was normal except for tonsillar enlargement and bilateral serous otitis media. Routine chest radiograph revealed a right posterior paratracheal mass with fine stippled calcifications (Fig. 1). There was no tracheal or esophageal compression. A 99mTc-pertechnetate blood pool study showed the mass not related to superior vena cava or aortic arch; the thyroid gland was normally located (Fig. 2). There was no uptake of the nuclide in the mass. A 99mTc-polyphosphate bone scan was normal. Normal laboratory findings included SMA-14, complete blood count, urinalysis, and urinary VMA. Intermediate strength PPD was negative. It was felt that neuroblastoma could not be excluded, and thoracotomy was performed. There was a large mass overlying the right main bronchus and trachea; the mass was comprised of matted enlarged lymph nodes and was adherent to the trachea. Most of the mass was excised. Frozen section revealed a granulomatous process. Bacterial and fungal cultures of the mass were normal. Microscopically, the parenchyma of the matted nodes were distorted by marked fibrosis and caseous necrosis. Around the periphery of the necrotic areas were proliferations of epitheliod cells and occasional multinucleated giant cells. Foci of calcification were noted within the caseous material and in areas of fibrous scarring. Special stains for acid fast organisms were negative. Methenamine silver stain, however, revealed the Histoplasma capsulatum



Fig. 1B. A coned frontal radiograph shows fine stippled calcification within the mass (arrow).

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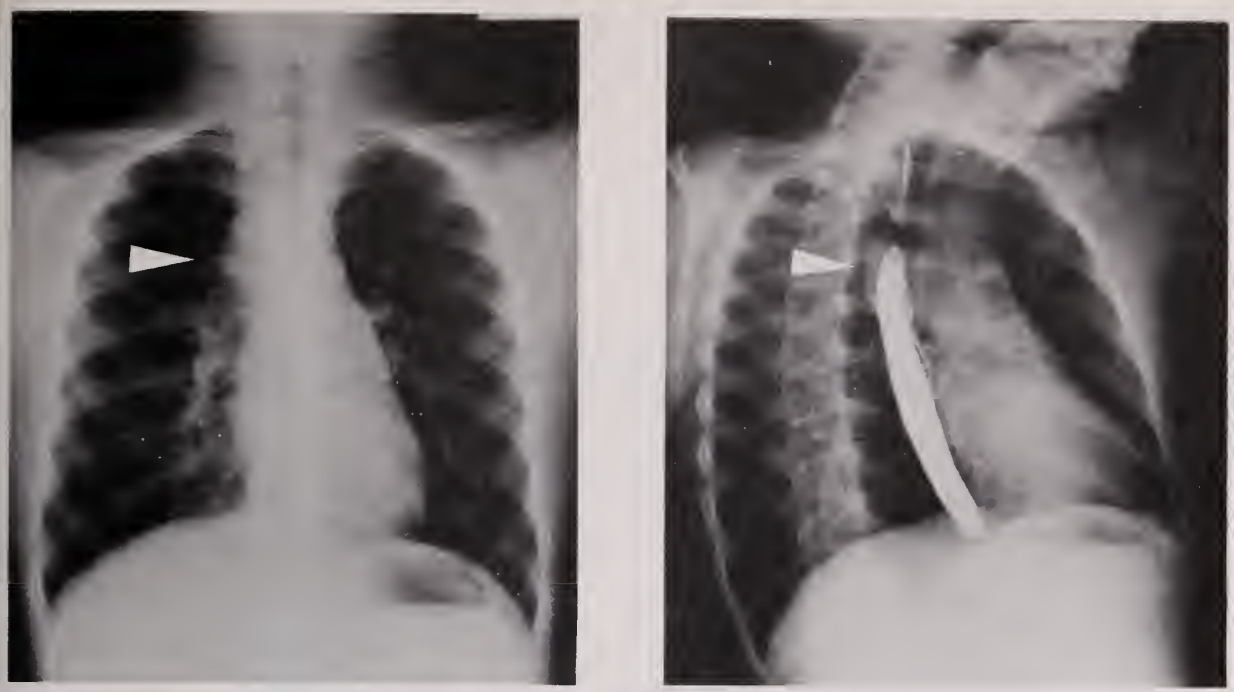


Fig. 1A. PA (left) and RAO chest radiographs show a lobulated mass adjacent and posterior to the trachea on the right (arrow).

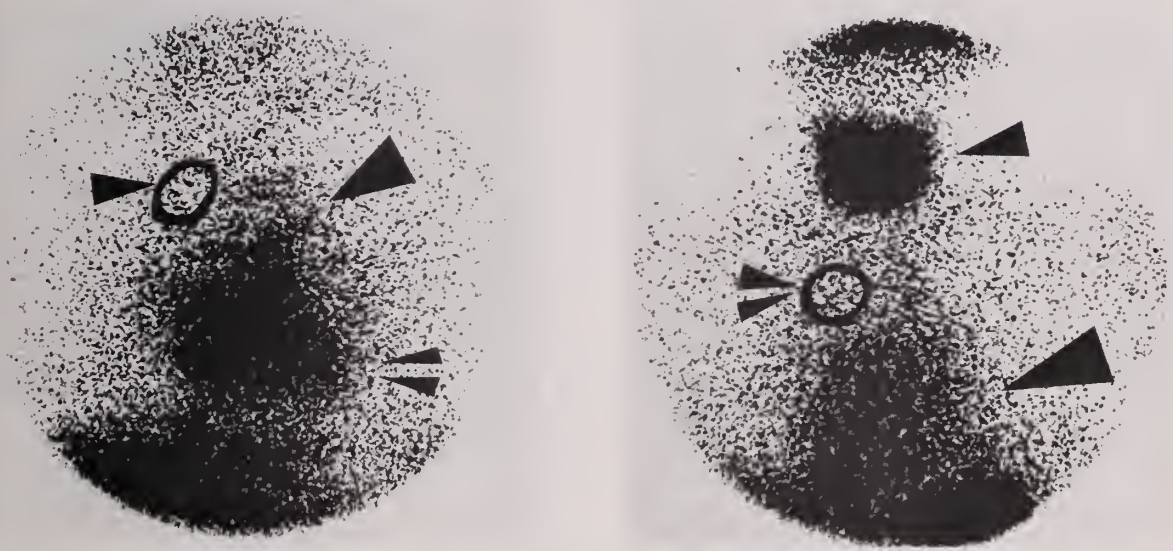


Fig. 2A (left). 99m Tc-pertechnetate blood pool scan shows no concentration in the region of the mass (small arrow). The intracardiac blood pool (double arrows) and aorta are evident (large arrow). Fig. 2B. Ten minutes later normal intense thyroidal uptake is evident in the neck (small arrow). The region of the mass is outlined (double arrows); the intracardiac blood pool persists (large arrow).

organism. The final pathologic diagnosis was Histoplasma mediastinal granuloma.

Discussion

Mediastinal granuloma accounts for about 6% of all mediastinal masses and is most common in adults. A caseous or fibrocaseous mass, the lesion is quite distinct from either mediastinal fibrosis or acute peribronchial lymphadenitis. In about one-half of adult cases the lesion is symptomatic, but cough, chest pain, dyspnea or symptoms of esophageal, tracheal or vena caval compression commonly occur. Relatively few cases have been reported in children under 10 years of age and most were apparently symptomatic. A definitive etiologic diagnosis is made in about one-third of adult cases. Histoplasmosis is the most

common etiology, and the organism is best identified by special silver stains on light microscopy. In children, the etiology may more often be tuberculosis than histoplasmosis. An etiology has been established in most reported cases in children. These children usually were symptomatic, and many showed compression of the trachea, a finding not seen in adults. The right paratracheal area is the most common location. The lesion may be heavily calcified and hence present little diagnostic problem. However, if the lesion has only stippled calcification or is not calcified, the radiographic diagnosis is certainly not clear and malignant lesions must be excluded. Mediastinal granuloma apparently may progress to mediastinal fibrosis[1-6]

The present case illustrates several important aspects of Histoplasma mediastinal granuloma in children although symptomatic in almost all reported instances, the lesion may be quite silent and may present as an incidental discovery during routine chest radiography. As in adults, a heavily calcified right paratracheal mass would strongly suggest a benign lesion. However, stippled calcification in such a mass in a young child is quite worrisome. Mediastinal granuloma may be suggested, but thoracic neuroblastoma must be excluded[7]; lymphoma, teratoma, thymoma and thyroid tumors may also have calcification[8-10]. Surgery is often necessary to establish a diagnosis. An uncalcified mediastinal granuloma presents even more diagnostic possibilities, and again surgery is usually necessary. In active, symptomatic lesions, skin tests or serologic techniques may establish the diagnosis. In quiescent lesions, these techniques are often not helpful.

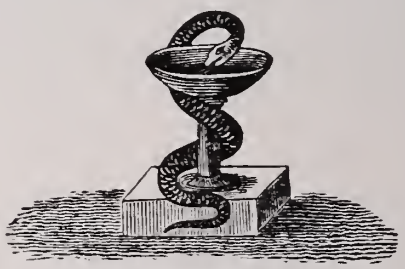
Although uncommon, mediastinal granuloma must be included in the gamut of asymptomic mediastinal masses in young children. Unfortunately, as noted, surgery may be necessary to establish the proper diagnosis.

Acknowledgments

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Peritoneoscopy: Its Expanding Role in Oncology

Stephen H. Rosenoff, MD, *Roanoke, Virginia*

In the light of today's sophisticated equipment and techniques, peritoneoscopy is discussed, and its use in oncology is reconsidered.

The terms laparoscopy and peritoneoscopy are here used interchangeably.

PERITONEOSCOPY is a simple procedure by which one can visualize the peritoneal contents. This procedure was first performed in man by Kelling in 1910.[1] Kelling addressed the German Surgical Society in 1923 on the subject of peritoneoscopy and pointed out that the postwar economic recession had necessitated the increased use of this procedure, since it saved his patients the long and costly stay in the hospital which a laparotomy would have entailed.[2] Since Kelling's initial observation, sporadic but enthusiastic reports extolling the virtues of this procedure have appeared in the medical and surgical literature.[3,4] However, it was not until the advent of sophisticated fiberoptic equipment in the present decade that the procedure became popular with obstetricians and gynecologists for the visualization of pelvic structures and the performance of routine tubal ligations.[5–7] More recently, the procedure has gained popularity with medical and surgical oncologists.[8]

Procedure

Although peritoneoscopy has been performed in treatment rooms on hospital floors and even as an outpatient procedure, it is the author's belief that it should be conducted in a more controlled environment, such as an operating room or an endoscopy suite adjoining the operating room. The procedure usually entails a 24- or 48-hour hospital stay. It may be performed under local or general anesthesia. The usual site for trocar insertion (7-mm diameter) is just below the umbilicus. A small skin incision (about 1.5 cm) is made and blunt dissection carried out to the rectus muscle fascia. Next, a Verres pneumoperitoneum needle is introduced and a pneumoperitoneum produced using CO_2 or room air. The adequacy of the pneumoperitoneum is then tested with syringe and needle as described by Steptoe.[5] The peritoneoscopy trocar and peritoneoscope can then be inserted into the peritoneal cavity and its contents inspected. Usually, the upper surface of the liver, the gall bladder, both leaves of the diaphragm and the omentum can be well visualized. With appropriate manipulation, the pelvis and its contents can also be seen. Biopsy of the liver or any suspicious structures, such as tumor nodules, may be performed under direct visualization. Following completion of the procedure, recovery is usually swift; the patient is able to eat within four to six hours and ready for discharge within 24 hours.

Uses of Peritoneoscopy

Peritonescopy has been utilized extensively by obstetricians and gynecologists to perform tubal liga-

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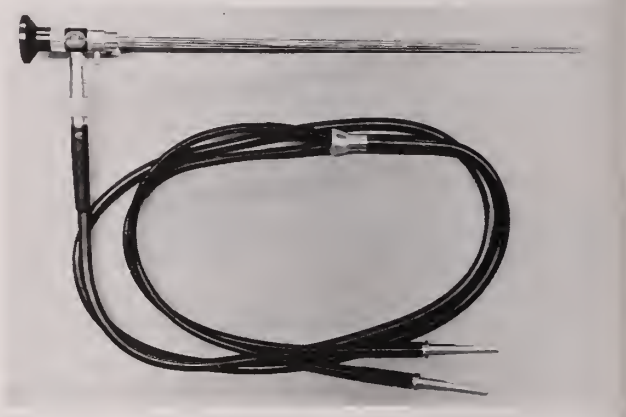
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tion[5-7] and more recently to retrieve foreign bodies (such as intrauterine devices) from the peritoneal cavity.[9] However, the real value of this procedure for medical and surgical oncologists and their patients lies in its potential as a diganostic tool, which on occasion spares the patient an abdominal exploration. Sugarbaker and his colleagues recently reported the use of preoperative laparoscopy in the diagnosis of acute abdominal pain.[10] Twenty-nine of their patients underwent laparoscopy prior to planned exploratory laparotomy. In 11, disease was found which required laparotomy, while in the remaining 18 a diagnosis was made which did not require laparotomy. These patients were saved a major surgical procedure, and no complications were reported from laparoscopy.

Potential For Oncology

As an outgrowth of the excellent visualization of both the right and left lobes of the liver and the ability to perform directed liver biopsies, peritoneoscopy has proved to be useful for the evaluation of patients who are suspected of having either primary hepatic cancer or metastatic disease involving the liver.[3,4,11-13] Important surgical and medical chemotherapeutic decisions often hinge upon the presence or absence of metastatic disease involving the liver. Unfortunately, neither the physical examination of the liver nor the evaluation of liver function tests affords security of diagnosis. Necropsy studies have shown that approximately 50% of livers containing metastases are of normal size[14]; furthermore, hepatomegaly may be produced by a variety of nonmalignant conditions. Additionally, although LFT's are often elevated in patients with liver metastases, they may be false-positive signs in 50% of the cases.[15] The radioisotopic procedure of liver scanning may assist with diagnosis. However, even if one utilizes the criteria of a "filling defect" as implying liver metastasis, this procedure is falsely positive approximately 20% of the time and falsely negative in 25% of cases studied.[16] This situation is then similar to that faced by the thoracic surgeon reviewing a chest x-ray demonstrating an isolated pulmonary nodule. Neither a shadow nor an equivocal biochemical test can replace a tissue diagnosis when important therapeutic decisions must be made. Of the invasive procedures available, the blind percutaneous liver biopsy is the simplest. Although helpful when positive, it is falsely negative 50 to 60% of the time[15] and thus cannot be considered diagnostic when failing to reveal cancer. Peritoneoscopy with directed liver biopsy, however, never gives a false-positive result and has a false-negative rate of only 10 to 15%.[12] Peritoneoscopy has thus been helpful when chemotherapeutic decisions hinged upon the presence or absence of liver metastases and the clinical situation was equivocal.

Another area where peritoneoscopy has proved useful to the oncologist is in staging of ovarian carcinoma and malignant lymphoma. In a study performed at the National Cancer Institute, peritoneoscopy was performed in patients with localized ovarian carcinoma as determined one month earlier by exploratory laparotomy.[8,17] Advanced disease was found in 56% and thus required a change in therapy. Most of these patients had their unsuspected metastatic disease located on the diaphragmatic leaves. Careful inspection of the diaphragmatic surfaces, either at the time of abdominal exploration or peritoneoscopy, is now considered by most gynecologic oncologists to be an integral part of the staging and evaluation of the patient with ovarian carcinoma. In the same National Cancer Institute study,[8,17] peritoneoscopy was found to be a useful tool for "second look" in those patients with advanced ovarian carcinoma who had achieved an apparently complete clinical remission with chemotherapy. Of these patients, 40% were found to have residual disease requiring continuation of therapy and were spared laparotomy in the process.



Fiberoptic peritoneoscope manufactured by Carl Storz with its accompanying light cable. The diameter of the trocar (not shown) through which this instrument is inserted is 7 mm.

Peritoneoscopy has also found a role in the staging of Hodgkin's and non-Hodgkin's lymphomas. Liver involvement in the non-Hodgkin's lymphomas is common and is found in 40 to 50% of patients at initial presentation.[18] Peritoneoscopy is capable of identifying 75% of these patients who have hepatic involvement with lymphoma, prior to exploratory laparotomy.[18] Bagley and his colleagues performed peritoneoscopy in the staging of patients with Hodgkin's disease.[19] They found the same frequency of liver involvement as when laparotomy staging was utilized. Although the false-negative rate for per-

itoneoscopic evaluation of the liver in patients with Hodgkin's disease has not yet been established, those patients found to have liver involvement by peritoneoscopy-directed biopsy can be spared an unnecessary exploratory laparotomy. In addition, peritoneoscopy may be utilized as a second-look procedure in patients with malignant lymphoma who had liver involvement prior to institution of chemotherapy and who have achieved an apparent clinical complete remission with treatment. As described earlier, in a similar clinical situation with patients with ovarian carcinoma,[8,17] many of these patients will be found to have unsuspected residual lymphoma and to require additional cytotoxic chemotherapy before pathologic, complete remission can be achieved.

A third area where peritoneoscopy may prove useful is for the preoperative evaluation by surgical oncologists of patients with intraabdominal cancers. In 1944, Benedict performed preoperative peritoneoscopy in 95 patients with gastric carcinoma.[4] Twenty (21%) were noted to have metastatic disease and laparotomy was avoided. More recently, Sugarbaker reported the use of preoperative peritoneoscopy in 23 patients with intraabdominal cancers.[13] In eight, laparotomy was avoided. In three more, potentially curative surgery could be attempted after intrahepatic metastases were excluded at the time of peritoneoscopy. These latter patients had abnormal LFT's and filling defects on liver scan. The potential thus exists for peritoneoscopy as an aid in the preoperative evaluation of selected patients by surgical oncologists.

Complications

Serious complications occur infrequently after peritoneoscopy. Reported complications include: 1) bleeding from biopsy sites[8]; 2) localized or extensive subcutaneous emphysema[8]; 3) postoperative wound infections[8]; 4) peritonitis[21]; 5) pneumothorax[8,19]; 6) perforation of a viscous structure with the trocar.[21] Reported overall complication rates vary from zero[10] to six percent.[17] Serious complications occur less frequently, one to two percent of the time.[8,8,10,17] The only serious complications encountered by either myself or my colleagues in over 200 peritoneoscopies include one patient with extensive, self-resolving subcutaneous emphysema and two patients who suffered self-limited postbiopsy bleeding which required transfusions of two and four units of blood. There have been no fatalities and no patient has required postperitoneoscopy surgical intervention.

Uncomplicated peritoneoscopy entails, at most, a 48-hour hospital stay. Although some authors have cautioned against the performance of peritoneoscopy in patients who have had prior abdominal surgery,[20,21] this author and his colleagues were able to perform peritoneoscopy in over 67 women with ovarian carcinoma with an overall complication rate of less than six percent.[17] All of these women had had at least one major abdominal surgical procedure prior to peritoneoscopy. Furthermore, this complication rate of approximately six percent was comparable to that seen when peritoneoscopy was performed as a routine staging procedure in over 200 patients with Hodgkin's and non-Hodgkin's lymphoma. There were no fatalities in either of these studies.[8,17] Other authors have also found peritoneoscopy to be a safe procedure when it is performed by experienced personnel.[6,10,13] This author and his colleagues feel that the determination of free space for trocar insertion by prepuncture aspiration with syringe and needle, as described by Steptoe,[5] has enabled a reduction in complications and risk.

Indications for Peritoneoscopy

- For patients suspected of harboring a malignancy which involves the liver or peritoneal or omental surface and has otherwise eluded detection;
- for patients found to have equivocal signs of liver involvement during their initial evaluation for cancer;
- for patients who have been successfully treated at an earlier time and are now suspected of having relapsed with liver or intraperitoneal metastases;
- as an initial staging procedure for patients with malignant lymphoma or ovarian carcinoma;
- for second look after apparently successful therapy in patients with malignant lymphoma or ovarian carcinoma;
- as a preoperative procedure in patients with intraabdominal malignancy.

Summary

The eventual role of peritoneoscopy in the armament of the oncologist will require more detailed study for its precise definition. However, peritoneoscopy is a tool which has improved our diagnostic capabilities and aided in the staging evaluation of patients with cancer, and it has often spared patients unnecessary abdominal exploration. This procedure has been available for over 60 years. Now that we have more sophisticated equipment and techniques, we should reconsider its use and its role in oncology.

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CANCER TRENDS COMMENT

The author has provided us with an excellent review of the indications for laparoscopy in the cancer patient. With the introduction of modern fiberoptic instruments, it has become apparent that this procedure is now of age. The use of the cold light source has eliminated the possibility of complications with a hot light source. This dramatic endoscopic technique provides a direct view of the contents of the anterior abdominal cavity, more than half of the liver, the gallbladder, the falciform ligament, the omentum, the tip of the spleen and the exterior parts of the stomach, small intestine, colon and the pelvic organs. It cannot examine the retroperitoneal lymph nodes, porta hepatitis, pancreas, kidneys or ureters.

Aside from the potential indications described by the author, we have found this technique extremely useful in evaluating the intrahepatic and extrahepatic biliary tree. In patients who present with obstructive jaundice and in whom the site of obstruction is not known and percutaneous transhepatic cholangiography cannot be performed, a cholangiogram can be performed under direct vision of the laparoscope. After introduction of the laparoscope, the gallbladder tip is visualized and a 20-gauge spinal needle is inserted through the anterior abdominal wall over the area of the gallbladder. The tip of the needle is then passed through the right lobe of the liver and into the gallbladder through its liver bed. (If the gallbladder is punctured directly through its peritoneal surface, biliary peritonitis may be a major problem.) A portion of the bile is then aspirated, and a radiopaque substance inserted into the gallbladder and x-rays performed. In most instances the dye will infuse into the biliary tree, localizing the site of obstruction. Using this technique, we have not had any problems with postoperative bleeding or bile drainage. In patients in whom the obstruction is caused by intrahepatic metastases, an unnecessary laparatomy may be avoided.

This procedure can be performed expeditiously, and in most instances a biopsy and/or cholangiogram can be performed in less than 30 minutes. When used correctly, laparoscopy with the available modern fiberoptic instruments has now been proven a well-tolerated, effective diagnostic procedure in patients with malignant disease.

Peter W. Brown, MD,
Assistant Professor of Surgery,
Medical College of Virginia, *Richmond.*



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Dr. Watson and the Jezail Bullet

Hampton R. Bates, MD, *Richmond, Virginia*

Wherein mysteries of a stiff shoulder and a barometric leg, souvenirs of the battlefield, are explored in a Holmesian manner.

AMONG THE MOST CELEBRATED of literary mysteries is the location of the wound that John H. Watson, MD, sustained on July 27, 1880, while serving with British forces at the Battle of Maiwand. The British withdrew after a day of fierce fighting, taking the wounded physician with them. Watson was invalided home on half-pay and achieved considerably more success as the partner and Boswell of Sherlock Holmes. The battle is an historical event of the Second Afghan War, and true believers in the Holmes-Watson saga have no doubts that Watson was there. However, like all fundamentalists, they encounter knotty problems trying to reconcile seeming inconsistencies in the written record.

The initial description of the wound was concise and clear. Watson wrote that he "was struck on the shoulder by a Jezail bullet, which shattered the bone and grazed the subclavian artery" *(A Study in Scarlet)*. We know that the left shoulder was injured because Holmes on first meeting Watson noticed the "stiff and unnatural" carriage of the left arm.

In a later report the good doctor seemingly contradicted himself with the statement that the bullet had passed through his leg, which "ached wearily at every change in the weather" *(The Sign of Four)*. In the same adventure Holmes twice referred to his friend's injured leg. Another reference was noncommittal as to location; Watson wrote of discomfort caused by the Afghan bullet which he had brought back in one of his limbs *(The Noble Bachelor)*.

Dr. Edward J. Van Liere published an ingenious explanation for Dr. Watson's apparent uncertainty.[1] He suggested that the injured artery became stenotic and the resulting "subclavian steal" on occasion reduced Watson's cerebral blood flow to the point that he forgot the site of his injury. This scholarly thesis by a well known physician and physiologist cannot be dismissed lightly. However, I think the weight of evidence is against it.

W. S. Baring-Gould reviewed the problem in detail and summarized many theories including those of several physicians.[2] Drs. Roland Hammond, John Dardess, J. W. Sovine, Reginald Fitz, Vernon Pennell, Julian Wolff and Samuel R. Meaker applied their medical and anatomical knowledge and produced much interesting and agreeable material. Dr. Sovine came close to the truth as I see it. He suggested that Watson, bending over a patient, was hit on the shoulder by a bullet that ricocheted downward under the skin of the chest, abdomen and leg before coming to rest in the calf muscles.

My own solution rests on literal interpretation of Watson's words and my experience with gunshot wounds. The bullet ricocheted from a bone in the shoulder after grazing the subclavian artery and then left the body at an acute angle to enter the leg, where it remained. The large exit wound caused by the tumbling missile allowed detailed inspection of the bullet path by a fellow medical officer, so that we know how closely the artery escaped rupture and how nearly the literary world lost the irreplaceable Watson. The shoulder wound was dressed hastily on the battlefield and was filled with good granulation tissue by the time Watson reached the base hospital. The shoulder required no further treatment, and the leg wound was so well healed that extraction of the bullet was not attempted. Thus our hero was left with a

scarred, temporarily stiff shoulder and a barometric leg.

I do not think other commentators have noted that a large exit wound must have been present to account for our knowledge of the status of the subclavian artery. A battlefield surgeon in 1880 would not have exposed a major artery by choice and Watson's wound did not require heroic treatment.

This singular affair of the Jezail bullet was conceived by Conan Doyle to give his readers the pleasure and challenge of using deductive reasoning. When Holmes said, "Art in the blood is liable to take the strangest forms," Watson could have replied, "A bullet in the body is liable to take the strangest path," and thereby have aborted nearly a century of speculation about his wound.

Acknowledgment

The author acknowledges with appreciation the correspondence of Drs. John D. Archer, Hill Barton, E. J. Van Liere, and Joe Sovine.

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The illustration below is from the original edition of *The Memoirs of Sherlock Holmes*, London, 1894. By permission, A & W Visual Library, New York, © 1975.



"HOLMES GAVE ME A SKETCH OF THE EVENTS."

VOL. I. APRIL, 1874. N

VIRGINIA Medical Monthly

LANDON B. EDWARDS, M. D.,
... of the Va. State Board of Health, Recording Secretary Medical Society of Virginia,
Editor and Proprietor.

EDO UT PROSIM.



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Annals of Advertising

THREE PHARMACEUTICAL firms whose advertisements appeared in the very first issue of The VIRGINIA MEDICAL MONTHLY in April 1874, are still advertising with us today, in 1976.That's over 100 years of loyalty, and it may well be some kind of an advertising record. The faithful trio: the **A. H. Robins Company; Reed & Carnrick; Sharp & Dohme,** today incorporated into Merck, Sharp & Dohme. They deserve a large salute, for over the years their advertising has contributed significantly to the nourishment of this journal.

The first A. H. Robins ad, in April, 1874, was a small insertion for Mr. A. H. Robins' "Prescription Dispensary" at 523 North Second Street, Richmond. "Pure Drugs, Rare Chemicals and Pharmaceutical Products for Physicians, Hospitals, Families, Infirmaries, Medical Institutions, etc.—Wholesale and Retail," is the message. Today that dispensary has grown to pharmaceutical greatness, and Robins places full-page, 4-color ads. These have been inserted this year in the January, February, May and October issues to advertise Donnagal, Allbee with C, Donnatal and the five Robitussins.

Reed & Carnrick was already a large firm in 1874, with premises on Fulton Street in New York City, and its advertising, in that first issue, was an emphatic two full pages. These extolled "A New and Important Remedy, Lactopeptine." Its recommended use: for "Dyspepsia, Chronic Diarrhea, Vomiting in Pregnancy, Constipation, General Debility, and all diseases arising from imperfect nutrition." Its price was listed as $1 an ounce for the powder; $1 a hundred for pills; $1.10 a pint for the elixir. In our January and March issues, 1976, Reed & Carnrick has offered Sidonna.

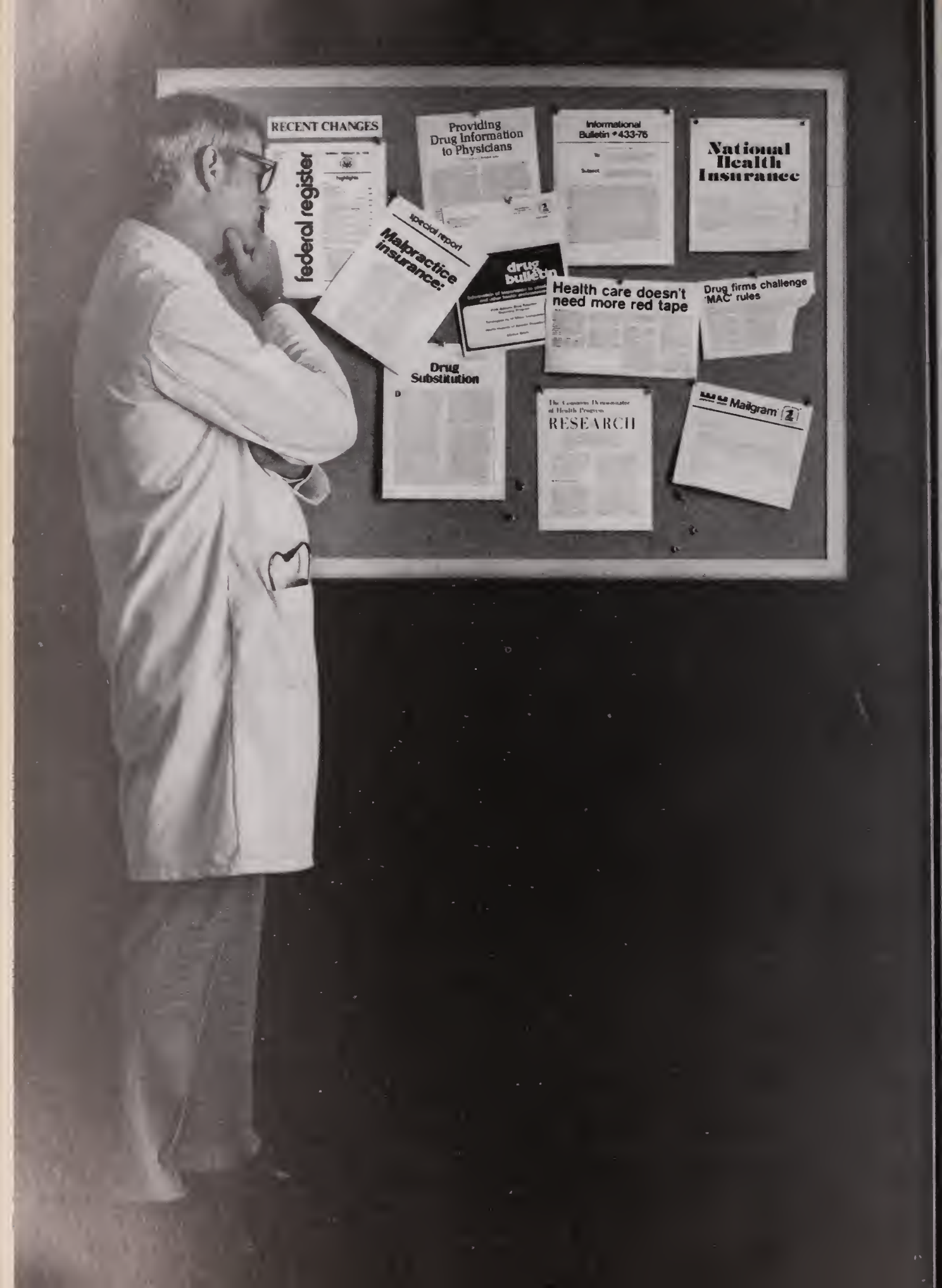
Sharp & Dohme was in business in nearby Baltimore in 1874, according to its ad in that first April issue. It is half a page, offering "Officinal and Other Standard Fluid and Solid Extracts, Choice Chemicals, and various other pharmaceutical preparations." Specifically, Sharp & Dohme was asking Virginia physicians to prescribe "Saccharated Pepsin, prepared from the stomach of the hog," as well as "Aromatic Cod Liver Oil," this either plain or with "the Hypophosphites of lime, soda, and potassa." Catalogues were being offered to provide prescription composition and dosage. This year Merck Sharpe & Dohme bought three pages in our February issue and three in August to advertise Indocin.

Two other pharmaceutical firms have advertising histories with us of extraordinary length. They are **Eli Lilly & Co.,** whose first ad appeared in the VIRGINIA MEDICAL MONTHLY of April, 1887, and **William P. Poythress & Co., Inc.,** a Virginia firm that began advertising with us in 1891.

Eli Lilly's ad in 1887 for half a page lauds "Succus Alterans (vs. Mercury)" as a cure for syphilis ("there is not a particle of doubt about it") and as having a "wonderful tonic and alterative effect in the myriad forms of scrofulous disease, in skin diseases, and in all cases where anemia is a factor." The preparation is credited to a Dr. McDade, whose monograph on syphilis was available on request. The Eli Lilly & Co. plant was then, and still is today, in Indianapolis. Currently Lilly takes twelve pages a year with us, paying premium for placement opposite the first page of text. This year these pages have urged Virginia physicians to prescribe Kefzol and Darvon, and an additional half-page insertion has described Nalfon.

William P. Poythress & Co., Inc., had its origins in Richmond retail, and the first Poythress ad with us, in 1891, describes the firm as "Pharmacists and Druggists" at 117 East Main Street. "Standard and Rare Drugs, Chemicals, etc.," reads the Poythress ad. "Toilet Articles, Surgical Instruments, Electrical Apparatus, and Rubber Goods. Agents for Virginia Bromide and Arsenic Water." Today the Poythress ads are full pages and in color; the December, 1975, insertion offered the Mudranes. Dr. A. A. Howser, Sr., a general practitioner, acquired the Poythress company in the 1920's and is still today, at the age of 95, its chief executive officer.

These, then, are heroic figures in our annals of advertising. They have created a venerable association, to be honored. May the partnership prosper through the appreciation of Virginia physicians.


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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

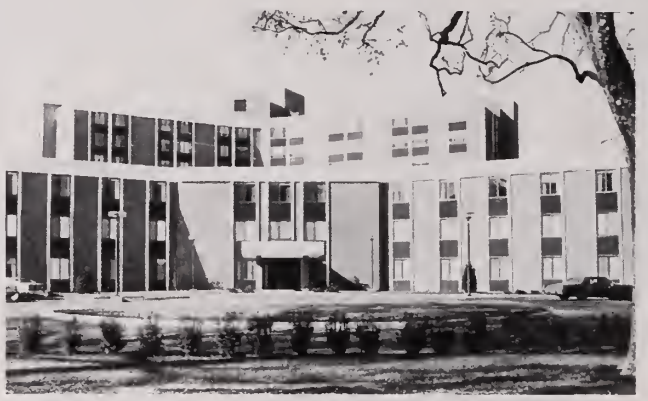
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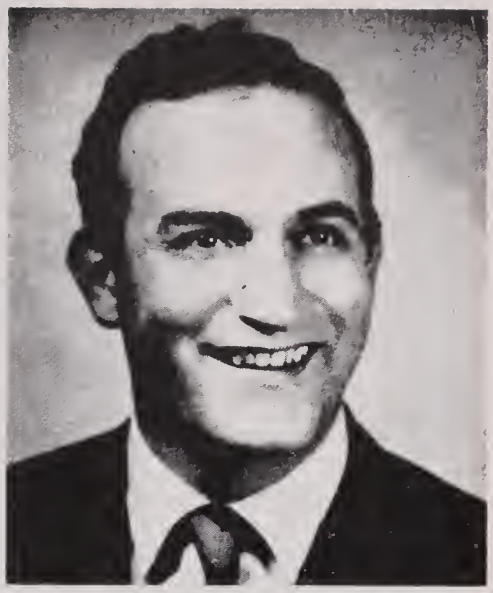
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Oriental Rugs



My name is Amir Zinat; I am Iranian. Years ago as a graduate student in the U.S., I noticed the big difference in the price of Orientals in my homeland and here. I have chosen, as my business, to sell these rugs at more reasonable prices. These rugs are selected by natives, are considered good investments and are exchangeable.

When buying Oriental rugs, you can make a better selection if you know something about them.

1. Your home is not a museum; it is a place for your comfort, pleasure and relaxation. When selecting an oriental rug, first evaluate how much you like a particular rug and then consider how it complements your decor.
2. All sizes and colors of Oriental rugs are available, suitable for every room in your home including the bathroom, hallways and steps, and a child's room. The money you are willing to invest in a rug should be relative to the degree of its use and enjoyment. Furnish with rugs first the rooms which are used most often.
3. When you have found several rugs you like, compare their prices. If two similar rugs vary considerably in cost, be sure you do not pay the higher price for very minor differences.
4. Color and design (the balance of different parts of patterns and the proper coordination between border and field) are important considerations in selecting a rug.
5. Do not hesitate in selecting a rug which to some may appear "too loud" or "too strong" since soft colors and simple designs often lose their novelty sooner in the home.
6. Oriental rugs are named after the village or, more often, the region of their origin. The quality of a rug may vary greatly regardless of the name. You should judge a rug by its individual merits (workmanship, wools, use of color and design) and not by its name or signature alone.
7. Some irregularity of shape, color, design and workmanship is acceptable in a handmade oriental rug. However, the discrepancies should not be extreme.
8. Natural silk rugs are expensive and are good investments. Be selective in your choice since some synthetic silk rugs are also available.
9. In antique rugs (50 years and older) age and condition are significant factors in judging the value of a rug. This does not necessarily mean that all older rugs have higher value. If a rug is old, it must be in very good condition, otherwise do not consider purchasing it.

I would be happy to help you learn more about Orientals and assist you in any way in your selection.

Please call **358-1711**

also recommend me to your friends

Thank you

Amir Zinat

Staples Mill Road near Broad Street

(in Cross Roads Shopping Center
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Richmond, Virginia

A resource for therapies, including a school for emotionally disturbed children

The Human Resource Institute of Norfolk offers individualized treatment programs within a therapeutic community to all ages and diagnostic categories of mentally and emotionally disturbed adults, adolescents, and children. By utilizing various individual and group therapies the patient becomes aware of his own feelings and his relationship to others. The diversified therapies increase the individual's self-esteem and encourage him to function in an effective manner.

An intensive program of community activities offered through the Rehabilitative Services Department promotes interpersonal relationships among patients and staff, and stimulates the patient's creative potential. Activities such as dance therapy, recreational therapy, occupational therapy, psychodrama, and music therapy, are individualized according to the patient's needs.

An integral part of treatment for the emotionally disturbed adolescent or child is the continuance of his education in a therapeutically controlled environment. HUMAN RESOURCE ACADEMY, a fully licensed and certified school, promotes learning with teachers specially trained in teaching the emotionally disturbed and learning disabled students.

Pharmaceutical therapy and close association with consultant physicians of all specialities are important aspects of patient care at Human Resource Institute.

To find out more about our comprehensive program contact the Co-Medical Directors, Dietrich W. Heyder, M.D., F.A.P.A., or Fathy A. Abdou, M.D., F.A.P.A., Human Resource Institute of Norfolk, Human Resources Building, 100 Kingsley Lane, Norfolk, Virginia 23505. Phone (804) 489-1072.

20/150 H

20/100 EAR

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20/30 YOU HAD YOUR HE

20/20 TESTED LATELY A SI

20/15 COMFORTABLE HEARING

20/10 INVESTMENT OF A FEW MIN

Hearing losses are among the most consistently neglected health problems. Many people with them won't even admit it to themselves, let alone others. A little encouragement may start them thinking about themselves more realistically.

That's why we're offering you the poster shown here. You can hang it on the wall or stand it on a small table. It comes with booklets called "As precious as sight" that give your patients some basic facts about auditory testing and hearing losses and how easy they are to correct in many cases.

Write to us for your free poster and booklets. They just might help you to help some patients who aren't hearing as well as they used to. Even those who ordinarily wouldn't hear of it.

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MEETINGS ABOUT MEDICINE

November

Psychiatric Illnesses in Children, sponsored by Eastern Virginia Medical School, Community Mental Health Center and Psychiatric Institute, Norfolk General Hospital and Schizophrenia Foundation of Virginia: Holiday Inn-Scope, *Norfolk,* November 12, SFV, Box 2342, Virginia Beach 23452.

Perspectives in **Pediatrics** #3, sponsored by Department of Pediatrics, University of Virginia School of Medicine, *Charlottesville,* November 11. Office of Continuing Medical Education, Charlottesville 22901.

Gastrointestinal Problems of Infancy and Early Childhood, sponsored by the Department of Pediatrics, Medical College of Virginia, at St. Mary's Hospital, *Richmond,* November 12. Barry V. Kirkpatrick, MD, Box 276, MCV Station, Richmond VA 23298.

Public Health Traineeship covering pediatric problems in rural health care, sponsored by the University of Virginia's Children/Youth Program, Ramada Inn, *Charlottesville,* November 15-17. Stipends available. Joseph R. Zanga, MD, Box 148, Charlottesville 22901.

Breaking Affective Barriers for the **Handicapped,** sponsored by Virginia Council on Health and Medical Care, Inc., Hotel Roanoke, *Roanoke, Virginia,* November 22-23. Edgar J. Fisher, Jr., Director, Virginia Council on Health and Medical Care, Inc., PO Box 12363, Central Station, Richmond 23241.

December

Recent Advances in **Clinical Medicine,** sponsored by Department of Medicine, University of Virginia School of Medicine, *Charlottesville,* December 1-3. Office of Continuing Medical Education, Charlottesville 22901.

Coronary, Valvular and Myocardial **Heart** Diseases—Structure-Function Correlations, sponsored by the American College of Cardiology: Williamsburg Conference Center, *Williamsburg,* December 7-10. Miss Mary Ann McInerny, 9650 Rockville Pike, Bethesda, MD 20014.

Infectious Disease, sponsored by Department of Pediatrics, University of Virginia School of Medicine, *Charlottesville,* December 9. Office of Continuing Medical Education, Charlottesville 22901.

January

Allergy, sponsored by Department of Pediatrics, University of Virginia School of Medicine, *Charlottesville,* January 13. Office of Continuing Medical Education, Charlottesville 22901.

The Alton D. Brashear Postgraduate Course in **Head** and **Neck Anatomy,** sponsored by the Department of Anatomy in cooperation with the Division of Continuing Education, School of Medicine and School of Dentistry, Medical College of Virginia *Richmond,* January 17-20. Dr. Hugo R. Seibel, Department of Anatomy, Richmond 23298.

Neurosurgical Society of the Virginias Annual Meeting: The Homestead, *Hot Springs,* January 20-22. Program Chairman, Dr. D. Ferry, 213 McClanahan Street, SW, Roanoke VA 24014.

February

Renal, sponsored by the Department of **Pediatrics,** University of Virginia School of Medicine: *Charlottesville,* February 10. CME Office, Charlottesville VA 22901.

Mid-Atlantic Section of the American **Urological** Society, sponsored by the Department of Urology, University of Virginia School of Medicine: *Charlottesville,* February 26. CME Office, Charlottesville VA 22901.

VIRGINIA MEDICAL EDITORIAL

Rural Medicine, Then and Now

THE PRACTICE OF MEDICINE in rural areas of Southwest Virginia around the turn of the century was elementary. There was a shortage of doctors. And of those there were, not all were college trained; unfortunately, some became doctors almost overnight. If they became dissatisfied with jobs such as teaching in one-room schools or working on farms, they turned to "the practice of medicine". A few of these fellows worked under other doctors, a sort of preceptor arrangement, for a few months. Others who lived in the more mountainous areas bought a couple of medical books, filled saddlebags with supplies of calomel, quinine, powders, laudanum, mountain herb preparations, mustard, and the like and were in business.

There were many cases of typhoid fever; the chief methods of treatment were starvation and dehydration. The doctors were scared to death of rupturing the thin Peyer's patches. Some aggressive patients enhanced their chances of survival by bribing members of their families to slip water and food to them when the parents and the doctors were not looking. Patients with acute abdomens were diagnosed as having "cramp colic" and treated with poultices and cathartics; these usually died of acute appendicitis. Random doses of powders were dispensed in folded paper packets. Powdered mountain herbs and leaves were dissolved in whiskey or brandy. Mustard plasters and poultices were used extensively.

There were but few hospitals in the early days, and only the very serious cases were hospitalized. The rural doctors and midwives delivered nearly all the babies in country homes. Fractures were "set" and splinted with boards held in place by rag bandages—



Dr. Rollie T. Akers photographed 70 years ago as he set out on his horse to make house calls in the Alum Ridge district of Floyd County, Virginia, his saddle bags loaded with pills. The roads and trails were in such poor condition that horseback travel was the only means of reaching many mountain homes. It is hard to realize the suffering Dr. Akers endured from rain and sleet on cold winter calls. He was known to return home with his shoes frozen to the stirrups of his saddle; his wife had to pound his feet loose with a heavy piece of wood before he could dismount. When roads improved, he sometimes used a buggy, and finally he purchased a Model T Ford, the first motor car in his community. Born in 1858, Dr. Akers began his practice in Floyd County in 1882 and continued it for 54 years. He died in 1941.

vithout the benefit of x-rays. A trip to the hospital vas quite an ordeal. It required a long ride by wagon or buggy over terrible roads and often a long train ide from the nearest railroad station.

A few of the better-trained and bolder physicians egan doing operations in the home—on the kitchen able. The rural doctor's office usually consisted of wo rooms, a front waiting room and a small back xamining room. The waiting room had a long coun- er on one side, drug shelves along one wall and a ot-bellied stove in the middle. A few doctors in



This country doctor's office was built and occupied by a rural Virginia physician in the early 1900's and still stands n the community of Willis, Floyd County. It is about 14 × 20 feet in size, with a severely simple interior of two rooms and fancy woodwork on the gable. This little building is ypical of many of the country doctors' offices in Southwest Virginia at the turn of the century.

small towns started one-man hospitals. A flat or resi- dence with enough floor space to accommodate the doctor's office, an operating room, and three or four rooms for bed patients was obtained. A "trained nurse" was hired, and arrangements were made with a surgeon in an urban center to come on call to do the major surgery. We speak of the "good old days", but they were not so good in the rural practice of medi- cine—except in those days malpractice was little more than a word in the dictionary.

The rural public of that time had some queer ideas about doctors and medical subjects. They thought that capsules would break and cut their stomachs. The medicines were emptied into cups of water and the little empty "glass bottles" returned to the doctors.

Every home had its camphor bottle and bag of asafetida, and poultices were used to "take the fire out of burns". The patients did not understand anything about germs. One of the doctors of the old school told of his experience in treating a boy with typhoid. When he explained to the mother that her son was better, she said, "I allowed that he would be, because I think I caught that old typhoid germ that was making by boy sick. It was about an inch long and was crawling along the edge of the spring branch."

The coming of good roads, the automobile, better communications, more education, rural electrification, a drug store in every town and the building of community hospitals have revolutionized rural medical practice in Southwest Virginia. Physicians serving in the rural areas now have the same training as their city colleagues, belong to the same state and national medical societies and read the same medical journals. When city doctors are using a new antibiotic, steroid or tranquilizer, you can be sure that the rural family physician is using it, too. Every person now living in Southwest Virginia can get adequate



Today in rural Virginia well-equipped rescue squads such as this one in Floyd County take patients swiftly to modern hospitals. This squad has four ambulances and is manned by over 30 trained volunteers, men and women.

medical attention, equal to any section of our state. Private automobiles and funeral home and rescue squad ambulances can carry any of our citizens to a well-staffed hospital within thirty minutes to an hour's time.

F. Clyde Bedsaul, MD, *Floyd, Virginia.*

The pictures on these pages were assembled by the author, who this year becomes a 50-Year Club member of The Medical Society of Virginia.

VIRGINIA MEDICAL EDITORIAL

Beverley R. Wellford, MD, 1797–1870



IN THE September issue of the VIRGINIA MEDICAL MONTHLY our esteemed Editor, W. T. Thompson, Jr., paid a well deserved tribute to our fellow Virginian, Richard E. Palmer, upon his inauguration as President of the American Medical Association.

Dr. Thompson wrote a number of very appropriate things about our new President, all of which were correct, but a slight error crept into the caption, which stated that Dr. Palmer was the third Virginian to become President of the AMA. As a matter of fact, Dr. Palmer is our fourth President.

It is easy to understand why Dr. Thompson overlooked our first President, for "Tee" is considerably further removed chronologically from Dr. Beverley Randolph Wellford than is your present writer. It is not generally known that 275 delegates to the fifth annual AMA convention met on May 4, 1852, in Richmond's Second Presbyterian Church on Fifth Street just a few steps north of Main. The church stil stands and is used daily by its original and very activ congregation.

At the meeting in 1852 Dr. Wellford was electe President and served the following year. He and Dr Hunter McGuire shared the distinction of havin been presidents of what are now the Richmond Acad emy of Medicine, The Medical Society of Virgini and the American Medical Association. The lat Walter B. Martin of Norfolk and Dr. Palmer o Alexandria also achieved this triple distinction i their respective local societies.

To return to Dr. Wellford, he was the third gener ation of physicians but the first by that name to b born in Virginia. His father, Robert, was a Britis army surgeon during the American Revolution Word of his humane treatment of American prison ers reached George Washington's ear, and at th conclusion of the war he sent for young Wellford an asked him to settle in Virginia. He doubtless sug gested that he locate in Fredericksburg, for here h filled the void that followed Dr. Hugh Mercer's deat in the Battle of Princeton.

His son, Beverley Randolph, was one of nine chil dren and he also practiced in Fredericksburg prior t his moving to Richmond, where he practiced an taught in the Medical College of Virginia. He, i turn, had two medical sons. His elder son, John Spotswood Wellford, was a founder of the new state wide Medical Society of Virginia and President of th Richmond Academy of Medicine. His second so was Armistead Nelson Wellford, father of Armistea Landon Wellford and grandfather of the late Dr Beverley Randolph Wellford, who practiced in Rich mond and is still sorely missed despite his death 1 years ago.

So we must not leave out our first President of th AMA, for he not only fathered outstanding Virgini physicians but also added luster to the office that ha just been conferred upon Dr. Palmer.

Harry J. Warthen, MD
Richmond, Virginia

Thank you, Dr. Bailey!

The Editors note with regret that Robert L. Bailey, Jr., MD, Richmond, will no longer be a reviewer and consultant on the many manuscripts received by the journal office.

Unknown to most of our readers, this valuable service by Dr. Bailey has been of major importance in the proper functioning of the VIRGINIA MEDICAL MONTHLY. We thank Dr. Bailey for his knowledgeable and faithful contribution and give him our deep appreciation.

LETTERS TO THE VIRGINIA MEDICAL EDITOR

A Vote in Favor Of AMA Membership

The American Medical Association is the only organization that represents the entire medical profession. It is the only organization that can speak for all physicians. Never have the times been more critical for American physicians than they are today. Never have we had a greater need for a strong unified association.

What does the AMA do for you? It is the most effective organization dedicated to improving medical care through education. The AMA was the driving force that eliminated the diploma mills of 1910 and the Class B medical schools of 1930. We are now assured that all graduates of American Medical schools are qualified. Residency training programs are approved and supervised. Specialty boards are approved when they comply with rigid criteria. Continuing medical education at the AMA scientific sessions gives physicians the opportunity to learn about new developments in all fields.

In each session of Congress over 2,000 bills with medical implications are introduced. The Washington office must study each bill and decide whether to support it, oppose it, try to change it or take no action. Instead of having the negativistic attitude portrayed by the press, the AMA supports six bills for every one that it opposes. The legislative record is one we all can be proud of.

The Keogh bill was passed after intensive efforts of the AMA. This bill enables each physician to put aside for retirement $7,500 tax free each year.

Some complain that the AMA does not represent their viewpoints. No organization can represent the viewpoint of every individual at the same time. However, when there is proportionate representation in the governing body, the final policy will be a balanced consensus of different viewpoints. If one state has unified membership and another does not, the view of the one with the unified membership will prevail.

Some physicians expect their specialty societies to represent them. No specialty society can afford a large enough staff.

Recently the AMA sued the federal government to change such laws as utilization review, maximum allowable cost of drugs and health planning organizations. These suits are necessary if we are to decrease bureaucratic control over the practice of medicine. These suits cost money. This money comes from the dues of members.

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the sacrifices of our forefathers. The preservation of this freedom is expensive. It must be paid for by our own sacrifices. Those who are unwilling to pay their share of these costs will have earned the slavery that will be the fate of all of us if we do not support the organization that is working for us.

James M. Moss, MD,
Alexandria, Virginia.

A Call for Standards In Reporting Lab Tests

With the present emphasis on standards of care in the medical profession, it would appear that to avoid confusion, standards should be set when reporting on suggested new laboratory procedures or changes in techniques in performance of present procedures. Such a need is brought to attention by the article in the July issue, "The Significance of Cyclic AMP in Clinical Medicine"[1].

Diagnosis is still primarily made by awareness of clinical signs and symptoms evaluated by careful history and physical examination. There is a tendency to abandon procedures proven with time for the use of multiple, often exotic, laboratory tests which may only cloud the issue.

When discussing the value of a test, it is important that data be provided which reveals the predictive value of a test. That is, what is the probability that a particular test, if positive, in fact indicates disease? To make such an analysis, it is necessary to know the sensitivity (probability of disease being detected when present), specificity (probability of absence of disease being so labelled) and prevalance of the disease under study. A disease with low prevalance (and hyperparathyroidism is such) leads to low predictability, even when sensitivity and specificity are in the 95% range or greater[2].

In the article presented, we are told the AMP is present in many tissues and fluids. We are told that in some patients with diagnosed hyperparathyroidism, infusion of hormone did not affect the urinary cyclic AMP. We are told nothing about changes in such levels in persons with no diagnosed diseases. We are told nothing about changes in persons with other diseases associated with changes in circulating calcium such as fractures, general neoplasms or chronic renal disease. We thus know nothing about the indicators needed to justify the use of another test.

In using any test, it is important that we know the probability of false positives and false negatives. We do not want a disease which has serious consequences to be falsely labeled as present in large numbers of people (a likelihood with disease of low prevalance and sensitivity and specificity below 99.95%), neither do we want to miss disease which is treatable.

Just as the use of double blind studies is indicated for evaluation of drugs, it is necessary for evaluation of new laboratory tests, with particular attention paid to the indicators enumerated: sensitivity, specificity and predicability. I would suggest the setting of such standards for future reports on laboratory tests.

C. M. G. Buttery, MD,
Norfolk, Virginia.

References

1. Escobar MR, Weeks BA: The significance of cyclic AMP in clinical medicine. Va Med Mon 103:487, 1976
2. Galen RS, Gambino SR: Beyond Normality: Predictive Value and Efficiency of Medical Diagnosis. New York: Wiley Biomedical Publications, 1975

The above letter was referred to the author of the article in question, who offers the following reply:

The purpose of our article was to provide a limited presentation of the state of the art on cyclic AMP. It was not our intention to advocate the routine use of cyclic AMP determinations in the clinical laboratory.

We concur with Dr. Buttery's comments relating to quality control and standardization of laboratory procedures and their use mainly to confirm the clinical diagnosis.

Dr. Buttery's questions with reference to experimental controls of studies mentioned in our article were unfortunately not answered for the lack of space, but they can be satisfied in most cases by checking the references, which we will be pleased to provide on request.

In our institution, our major concern in offering a new laboratory procedure is that it meet acceptable standards of sensitivity and specificity as well as predictability. In writing the article we wanted to encourage further studies which may ascertain these parameters. We did not mean to imply that these standards had already been met for cyclic AMP.

Mario R. Escobar, PhD,
Richmond, Virginia.

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ostumed in red and white gingham, the Chorus of the Auxiliary to the Roanoke Academy of Medicine took the spotlight at the presi-ential inauguration of Dr. Richard E. Palmer at the AMA's June meeting in Dallas and sang a rousing patriotic medley. To the right may be seen the director, Mrs. Vedii Ayyildiz.

Virginia Physicians to Have New Phone Listings Indexed by Specialty

Those new physician phone list-ıgs by specialty, long bruited, are in ıe works for the yellow pages of irginia's telephone books.

Sales agents are to begin soliciting irginia physicians soon (by tele-hone, of course), beginning with ynchburg and progressing through ichmond, the Peninsula (Hamp-ɔn, Newport News, Portsmouth), Roanoke, Norfolk, Virginia Beach, and Danville. Solicitation will coincide with the prepublication dates of telephone directories in the localities.

Reproduced here is part of a page from the Milwaukee, Wisconsin, directory, showing the style of the new listings. The traditional MD entries, arranged alphabetically according to the practitioner's last name, are in the two outer columns of the page. The new "Specialty Guide" occupies the two central columns.

When will the Guide appear? Perhaps in 1977, if enough physicians subscribe. The cost? It will vary from city to city, but the rate will be figured in the manner of a regular additional listing; in the Richmond area this is $1.40 per month. The AMA has given the Bell System the green light to offer 51 specialty designations.

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Frisch Robert A 425 E Wis av----------276-1906
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3535 W Oklahoma av----------384-1372
If no answer call Medical Society-----271-4132

GUIDE

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If no answer call Medical Society-----271-2900
Res 8365 N Pelican la----------354-3556
Weinstein Michael B
5600 W Brown Deer rd--354-5360
If no answer call----------271-4131
Weistrop Leonard 425 E Wis av--------272-8950
Res ----------962-5378
Whalen Geo E
Gastroenterology

Nuclear Medicine

Nuclear Medicine Ltd
Dr Alan S Lieberthal
606 W Wis av----------271-3870

Obstetrics

Delfs Eleanor 8700 W Wis av----------257-5578
Res 1651 N121----------771-4912
Milwaukee Clinic Ltd 950 N35---------933-1560

Physicians & Surgeons–Doctors Of Medicine (M.D.)–(Cont'd)

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George Konstantine S
Orthopaedic Bone & Joint Surgery
8410 W Cleveland av----------321-2255
If no answer call Medical Society-----271-2900
Res 14880 Juneau blvd----------782-5313
George Philip G
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WHO'S WHO IN VIRGINIA MEDICINE

There are two physicians in the rural community of Mannboro, Virginia. They are **James L. Hamner, Sr., MD,** 83 years old, who has been practicing in the Mannboro area for more than half a century and is a past president of The Medical Society of Virginia, and **William H. Markel, MD,** 29 years old, who recently completed the Medical College of Virginia's family practice program.

And there's a shiney new medical center in Mannboro, Virginia. It cost $200,000 and is fully equipped for first-class outpatient treatment.

Put all that together and you have a dream come true for a community of about 500 persons.

Dr. Hamner's nephew, James A. Sydnor of Mannboro, headed up the group of Mannboro citizens who managed to collect the money for the construction of the center. It was, Sydnor says, "a total community effort." Sydnor operates a store at a crossroads in the Amelia County community; the new medical center sits, by Sydnor's estimate, 700 yards from the store and is surrounded by empty fields. Sydnor's store also houses the Mannboro post office and was founded by Sydnor's grandfather in 1895 when the Mannboro community was 66 years old. "I've done research," Sydnor is quoted as saying by columnist Shelley Rolfe in the Richmond *Times-Dispatch* of July 10. "There has been a doctor practicing here for 110 to 120 years. And it's strange, but in that time there have been only three doctors."

The new center has six examining rooms, a large treatment room, an x-ray room, laboratory, waiting rooms, staff lounge and a pharmacy for prescription drugs. It will serve about 8,000 Virginians, for Mannboro, which is about 35 miles southwest of Richmond, is close to Nottoway, Dinwiddie and Chesterfield Counties.

Gov. Mills E. Godwin, Jr., went to Mannboro for the formal dedication ceremonies of the new center. It was the day after Queen Elizabeth's visit to Charlottesville and the Governor could have used a rest, but it isn't often a rural community brings the dream of a medical center into reality.

Dr. Hamner couldn't attend the ceremonies; he was in Chippenham Hospital, Richmond, battling a back injury suffered in a fall. He is greatly beloved, and the Mannboro community is hoping he will soon join Dr. Markle in the new center.



The Mannboro Medical Center on the day of its dedication, July 11. In the tent in the background, especially erected for the occasion, Governor Godwin made his ceremonial speech. The sign of the center's leased pharmacy appears at the far right.

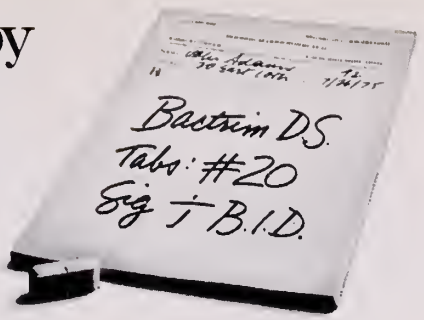


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0-day Bactrim therapy outperforms 10-day ampicillin therapy.



a multicenter, double-blind study of patients with ronic or frequently recurrent urinary tract infection, actrim 10-day therapy outperformed ampicillin -day therapy by 27.2%, when comparing patients no maintained clear cultures for eight weeks. riterion for "clear culture" was 1000 or fewer organ- ms/ml of urine.

While adverse reactions noted in this study were ild (*e.g.*, vomiting, nausea, rash), more serious reac- ons can occur with these drugs. See manufacturer's oduct information for complete listing. Maintain dequate fluid intake; perform frequent CBC's and inalyses with microscopic examination.

te: Bactrim tablets were used in these clinical trials. Bioequiv- ncy studies show one Bactrim DS double strength tablet is uivalent to two Bactrim tablets.

Bactrim™ DS
(160 mg trimethoprim and 800 mg sulfamethoxazole)
Double Strength tablets
Just 1 tablet B.I.D.

Bactrim™
(80 mg trimethoprim and 400 mg sulfamethoxazole)
2 tablets B.I.D.

For chronic or frequently recurrent cystitis and pyelonephritis due to susceptible organisms.

efore prescribing, please consult complete product information, a ummary of which follows:

dications: Chronic urinary tract infections evidenced by persistent acteriuria (symptomatic or asymptomatic), frequently recurrent infec- ons (relapse or reinfection), or infections associated with urinary act complications, such as obstruction. Primarily for cystitis, pyelo- ephritis or pyelitis due to susceptible strains of *E. coli, Klebsiella- nterobacter, Proteus mirabilis, Proteus vulgaris* and *Proteus organii.*

OTE: The increasing frequency of resistant organisms limits the use- ulness of antibacterials, especially in these urinary tract infections. he recommended quantitative disc susceptibility method (*Federal egister, 37*:20527-20529, 1972) may be used to estimate bacterial usceptibility to Bactrim. A laboratory report of "Susceptible to tri- ethoprim-sulfamethoxazole" indicates an infection likely to respond Bactrim therapy. If infection is confined to the urine, "Intermedi- te susceptibility" also indicates a likely response. "Resistant" indi- ates that response is unlikely.

ontraindications: Hypersensitivity to trimethoprim or sulfonamides; regnancy; nursing mothers.

arnings: Deaths from hypersensitivity reactions, agranulocytosis, plastic anemia and other blood dyscrasias have been associated ith sulfonamides. Experience with trimethoprim is much more mited but occasional interference with hematopoiesis has been re- orted as well as an increased incidence of thrombopenia with pur- ura in elderly patients on certain diuretics, primarily thiazides. ore throat, fever, pallor, purpura or jaundice may be early signs of erious blood disorders. Frequent CBC's are recommended; therapy hould be discontinued if a significantly reduced count of any formed lood element is noted. **Data are insufficient to recommend use in in- nts and children under 12.**

recautions: Use cautiously in patients with impaired renal or hepatic unction, possible folate deficiency, severe allergy or bronchial sthma. In patients with glucose-6-phosphate dehydrogenase defi- ency, hemolysis, frequently dose-related, may occur. During ther- py, maintain adequate fluid intake and perform frequent urinalyses, ith careful microscopic examination, and renal function tests, par- cularly where there is impaired renal function.

dverse Reactions: All major reactions to sulfonamides and trimeth- prim are included, even if not reported with Bactrim. *Blood dys- asias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, hrombopenia, leukopenia, hemolytic anemia, purpura, hypopro- hrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for children under 12. Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) every 24 hours
Below 15	Use not recommended

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole — bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10.

Oral suspension, containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole; fruit-licorice flavored — bottles of 16 oz (1 pint).

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In a multicenter study of patients with chronic or frequently recurrent urinary tract infectio

Bactrim was 27.2%* more effective than ampicillin in keeping patients infection-free for 8 weeks.†

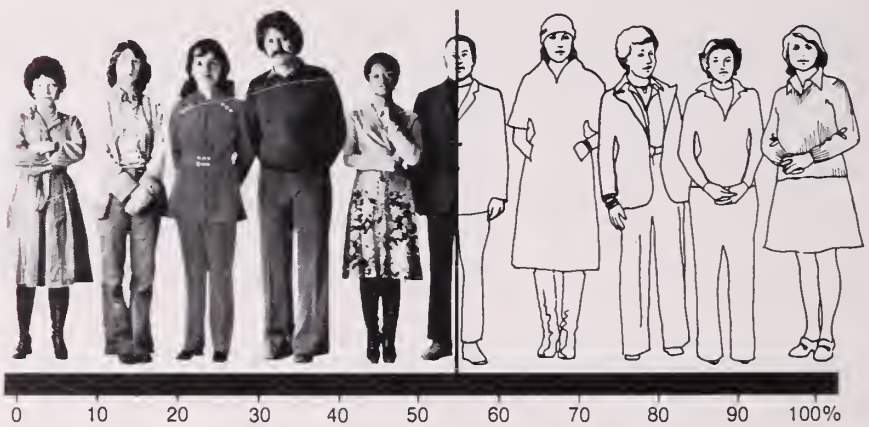
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Bactrim–70.5% of 78 patients infection-free at 8 weeks.



ampicillin–55.4% of 74 patients infection-free at 8 weeks.

*This percentage is arrived at by the statistical method of dividing the difference between Bactrim and ampicillin results (15.1%) by the percent of ampicillin results (55.4%).

†Data on file, Hoffmann-La Roche Inc., Nutley, New Jersey 07110

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(160 mg trimethoprim and 800 mg sulfamethoxazole)

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Please see summary of product information on preceding page.

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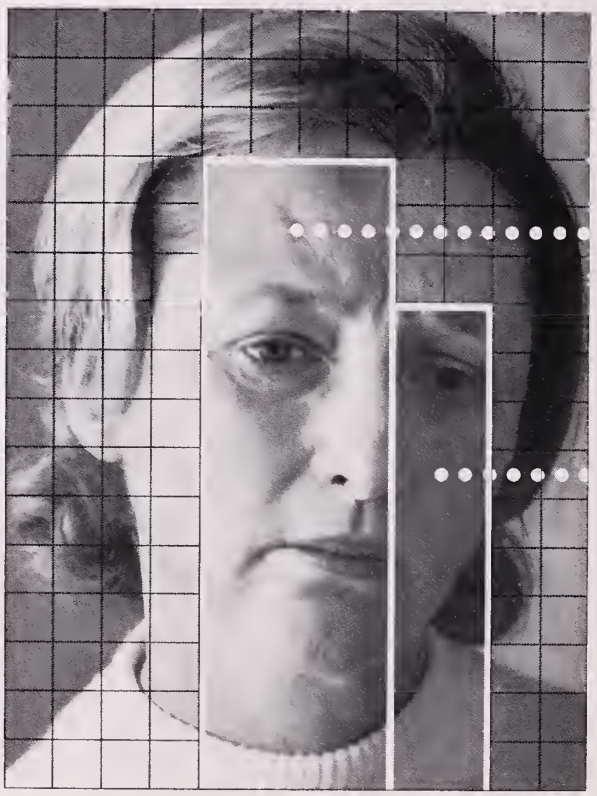
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Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major ymptoms, she is a psychoneu- otic patient with severe nxiety. But according to the lescription she gives of her eelings, part of the problem nay sound like depression. This is because her problem, lthough primarily one of ex- essive anxiety, is often accom- panied by depressive symptom- tology. Valium (diazepam) an provide relief for both—as he excessive anxiety is re- ieved, the depressive symp- oms associated with it are also often relieved.

There are other advan- ages in using Valium for the nanagement of psychoneu- otic anxiety with secondary lepressive symptoms: the psychotherapeutic effect of Valium is pronounced and apid. This means that im- provement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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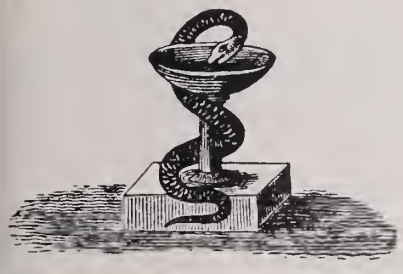
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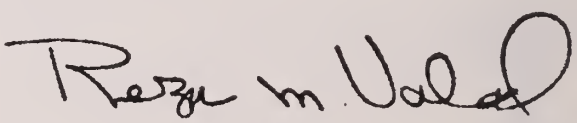
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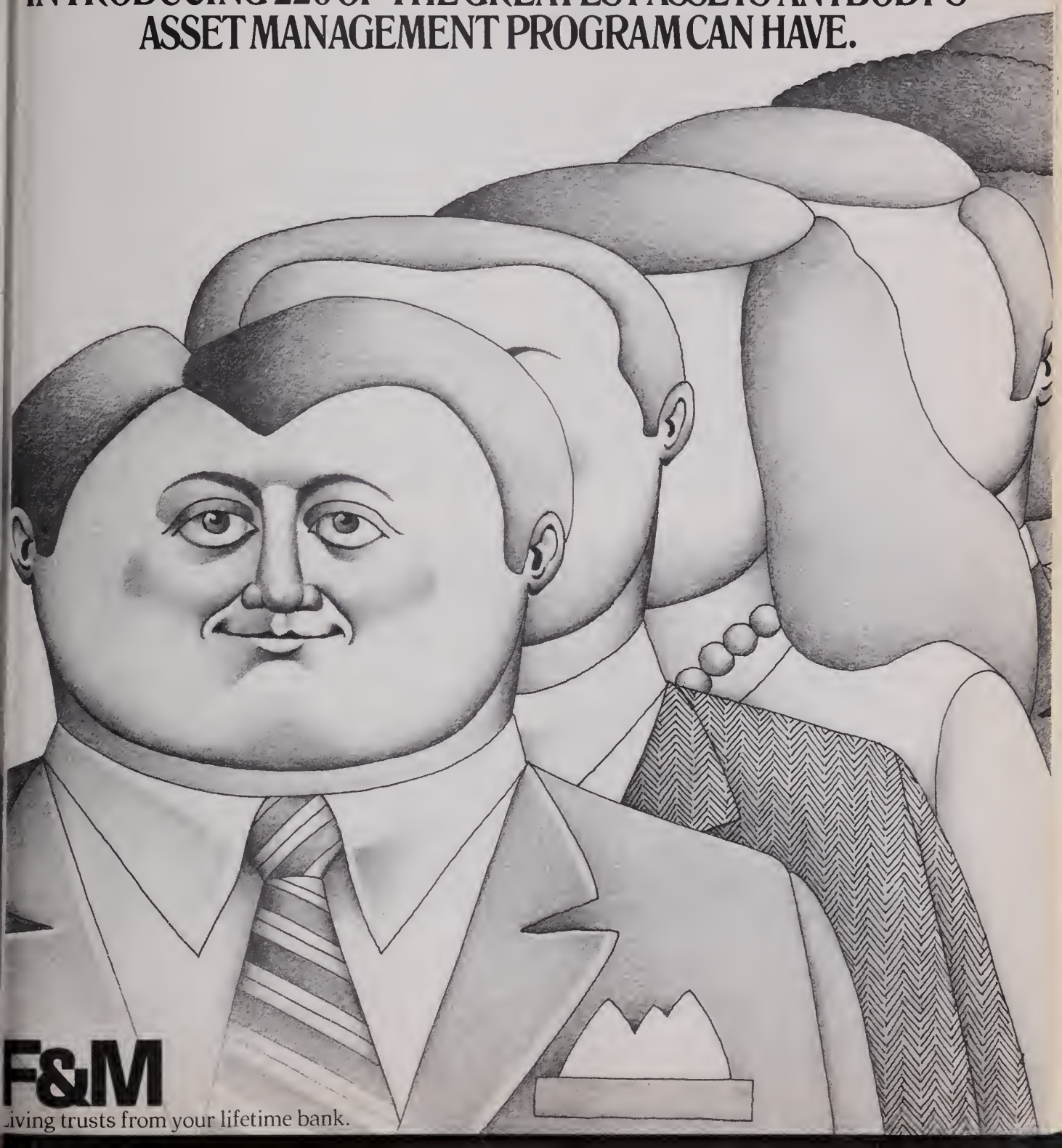
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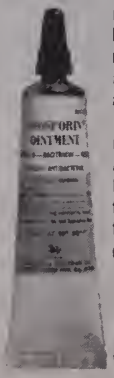
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INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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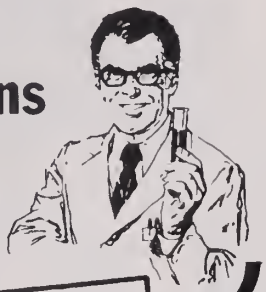
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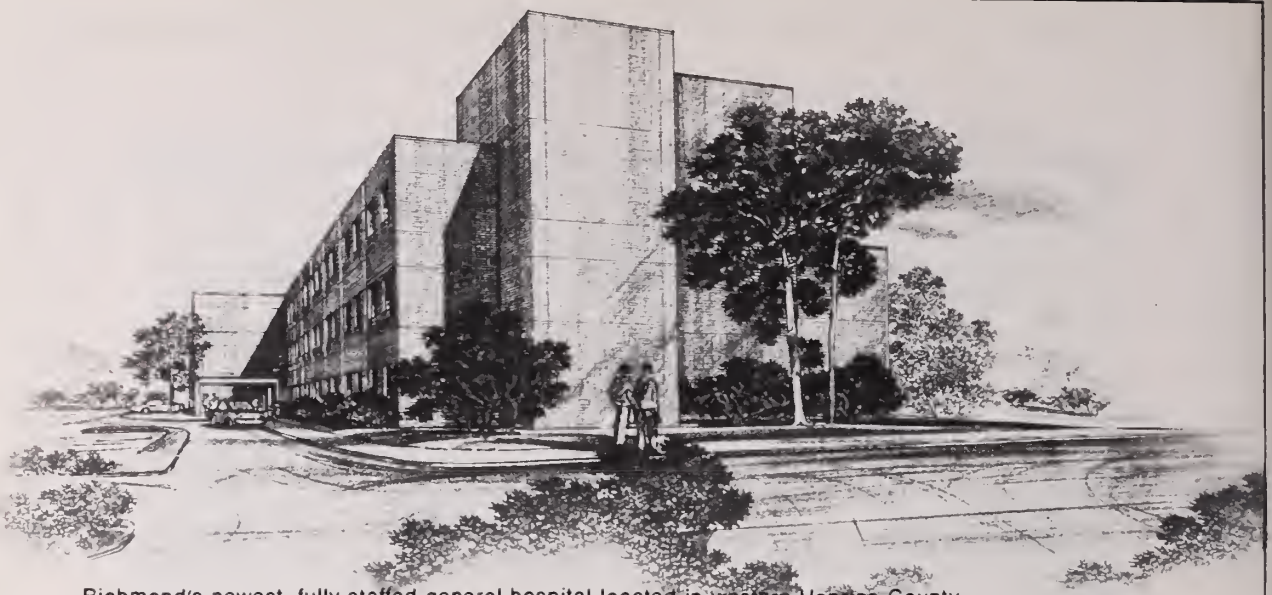
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My name is Amir Zinat; I am Iranian. Years ago as a graduate student in the U.S., I noticed the big difference in the price of Orientals in my homeland and here. I have chosen, as my business, to sell these rugs at more reasonable prices. These rugs are selected by natives, are considered good investments and are exchangeable.

When buying Oriental rugs, you can make a better selection if you know something about them.

1. Your home is not a museum; it is a place for your comfort, pleasure and relaxation. When selecting an oriental rug, first evaluate how much you like a particular rug and then consider how it complements your decor.
2. All sizes and colors of Oriental rugs are available, suitable for every room in your home including the bathroom, hallways and steps, and a child's room. The money you are willing to invest in a rug should be relative to the degree of its use and enjoyment. Furnish with rugs first the rooms which are used most often.
3. When you have found several rugs you like, compare their prices. If two similar rugs vary considerably in cost, be sure you do not pay the higher price for very minor differences.
4. Color and design (the balance of different parts of patterns and the proper coordination between border and field) are important considerations in selecting a rug.
5. Do not hesitate in selecting a rug which to some may appear "too loud" or "too strong" since soft colors and simple designs often lose their novelty sooner in the home.
6. Oriental rugs are named after the village or, more often, the region of their origin. The quality of a rug may vary greatly regardless of the name. You should judge a rug by its individual merits (workmanship, wools, use of color and design) and not by its name or signature alone.
7. Some irregularity of shape, color, design and workmanship is acceptable in a handmade oriental rug. However, the discrepancies should not be extreme.
8. Natural silk rugs are expensive and are good investments. Be selective in your choice since some synthetic silk rugs are also available.
9. In antique rugs (50 years and older) age and condition are significant factors in judging the value of a rug. This does not necessarily mean that all older rugs have higher value. If a rug is old, it must be in very good condition, otherwise do not consider purchasing it.

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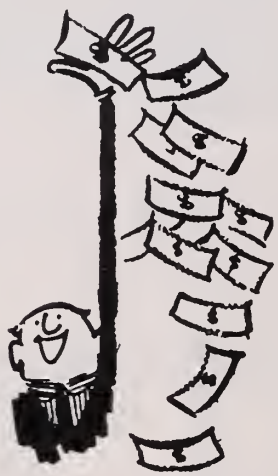
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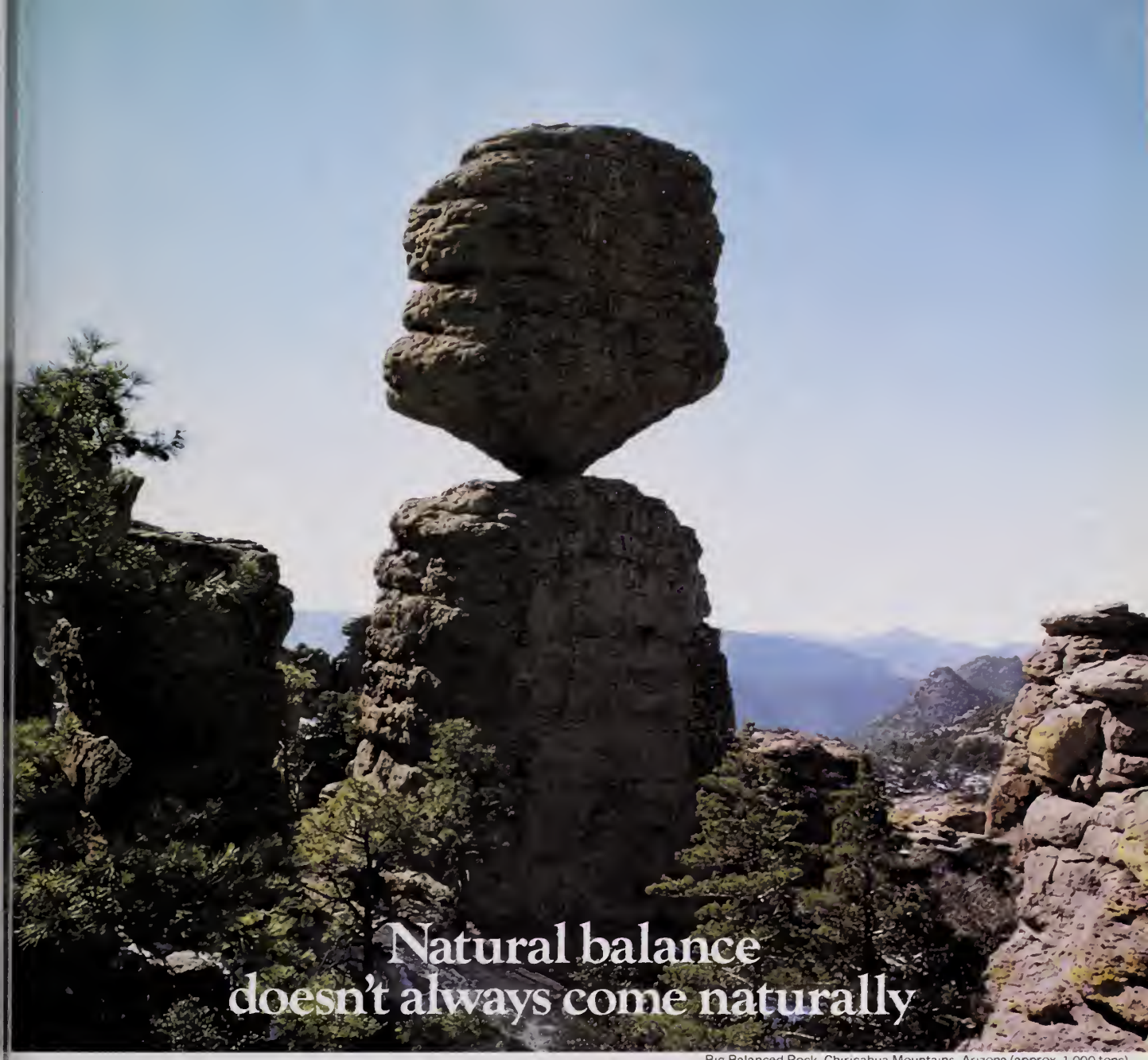
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*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

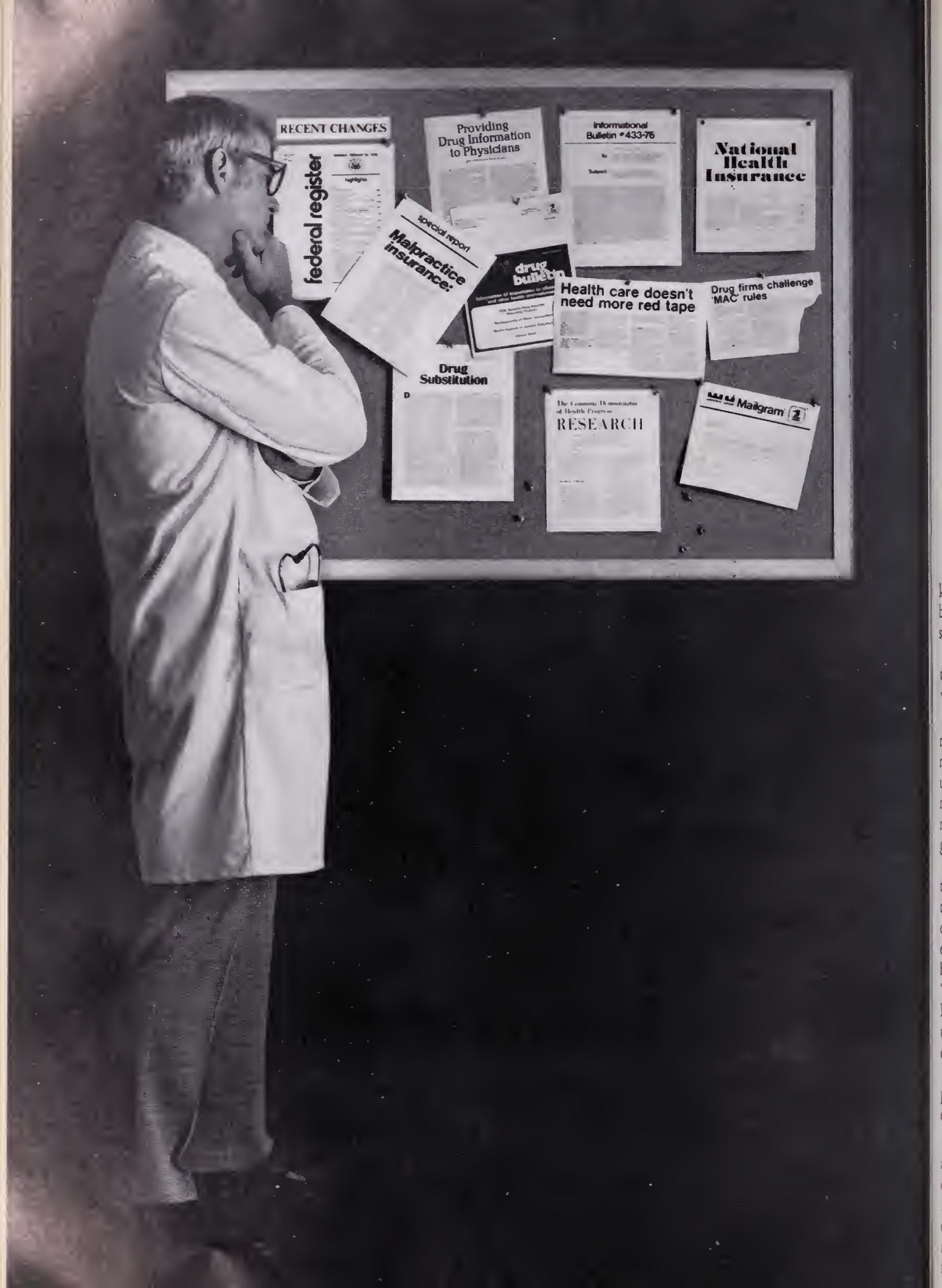
ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.

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And, of course, government standards alone do not assure the efficacy and consistency—the quality of each drug you prescribe.

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VIRGINIA MEDICAL

ume 103 December, 1976 Number 1

THE ANNUAL MEETING promised to be contentious, and so it was. Two touchy issues, unified membership and compulsory continuing education, pressed for admittance to the Society's by-laws, and everywhere the debate waxed thick and hot—as thick and hot as the air of the meeting rooms. From the House of Delegates to the Reference Committees and back again the two issues travelled, pounded by pro's and con's. Everyone in the Williamsburg Conference Center waited for the outcome. On the third day of the meeting, when the Delegates went into their second session, it looked probable that the proposal to require AMA membership would fail and the resolution requiring CME would succeed.

But then both measures hit a legal impasse. When the House of Delegates opened its concluding meeting to the membership, several of the local societies came forward for the vote with sheafs of proxies. No provision had been made for proxy vote at this ultimate session, nor, as the members proffering the proxies freely admitted, had the proxies been validated. Were they admissible? It was a critical question, for these absentee ballots could tip the scales. Back and forth went the argument, as passions aroused by the two central issues focussed on the sudden legal snarl. At 7:30 pm on Saturday night, when the meeting had been in session since early afternoon and the banquet guests had been waiting an hour, the exasperated doctors gave up and voted a postponement. Research in depth will be conducted. Lawyers will be consulted. And, in all probability, a special session of the membership will be called in 1977.

The January issue of VIRGINIA MEDICAL will carry a full report of this remarkable action, in minutes by the Executive Vice-President. Watch for it. You will also find there the decisions on myriad other key resolutions. Saliently, it was decided to aid and abet malpractice countersuits when justifiable. And votes for and against 35 bills to be considered by the General Assembly in 1977 were registered, including a package of physician disciplinary bills to step up the policing of competency. It will be a heavy legislative year.

On the following six pages are pictures of MSV members at this meeting.

The Medical Society of Virginia's Annual Meeting 1976

1.



The House of Delegates convenes. **1.** Speaker **William Hagood, Jr.,** is shown at the podium as he introduced D **Raymond S. Brown,** President (seated left), whose pre dential address was early on the agenda. In subseque proceedings Dr. Hagood was chosen the Society's Pre dent-Elect. **2.** and **3.** Views of the seated delegates. Extra! Advance copies of the November issue of VIRGIN MEDICAL featuring Dr. Brown's address are distribut immediately after he finished speaking. Dr. **Charles V Coppedge** is the teller. **5.** The Credentials Committ checks in the delegates. From right to left, Drs. **James Jones, Gerald C. Burnett** and **Munsey S. Wheby,** and sta member Mary Candler.

2.



3.



4.



5.



The Medical Society of Virginia's Annual Meeting 1976

1.



1. Members converge on the registration area. A total 616 physicians were registered by staff member Marga Brown (background). 2. Reference Committee One l tens to opinion from the floor: from left, Drs. **J. Thom Hulvey, William R. Watkins, Wesley C. Bernhart,** Cha man **George E. Broman, Jr., Robert A. Morton, Nichol G. Colletti, J. Leo Crosier, William E. Painter** and **W liam M. Eagles.** 3. In the meeting of Reference Committ Two. Dr. **John A. Martin** speaks to the question of u fied membership. 4. Drs. **H. H. Ferrell, Jr.,** and **Charl E. Davis, Jr.,** converse. 5. The Drs. **Hatfield, C. C.** (le and **William H.,** discuss family genealogy. They met f the first time at the meeting and when this picture w taken had documented mutual fifth cousins.

2.





3.





sidents past and present discuss the issues: **1.** Drs. **orge M. Nipe** and **W. Leonard Weyl,** who received the sidential gavel from Dr. Brown at Saturday night's nquet; **2.** Executive Vice-President **Robert I. Howard** d Dr. **William R. Hill; 3.** Drs. **Carl E. Stark** and **lcolm Tenney, Jr. 4.** The 4th district caucuses in Coun- or **G. G. Birdsong**'s room: clockwise from Dr. Birdsong far right, Drs. **Robert G. Edwards, Charles H. Townes, nry M. Snell, Arthur A. Kirk, L. L. Davis** and **Anthony Munoz.** The Portsmouth Medical Society was host for e meeting, and Dr. Kirk was Chairman of Arrange- nts. **5.** The Auxiliary President, **Mrs. Harold L. Wil- ms** (right), confers with **Mrs. Fay I. Carr, Jr.,** as she epares to preside at the Annual Luncheon.

3.





4.





5.



The Medical Society of Virginia's Annual Meeting 1976

1.



2.





3.





1. Enjoying the putting green, Drs. **Charles McD. G ham, Jr.,** and **William P. Tice. 2.** Watching others p after their own tennis matches: from left, Drs. **Robert Woodhouse, III, C. Barrie Cook, Eugene O. S. Stevens** and special guest **Raymond Scalettar,** president-elect the District of Columbia Medical Society. **3.** Intent on t score at the bridge table: clockwise from left, **Mrs. Ra mond S. Brown,** Dr. **C. M. G. Buttery, Mrs. Nelson H** and Dr. **James Vincent Scutero.** Dr. Scutero was cha man of the bridge tourney. **4.** Dr. **Nelson M. Smith** stud Dr. **Ira D. Green**'s scientific exhibit, a sonographic de onstration of cholelithiasis. **5.** At the hobbies exhib Drs. **W. E. Schlabach** (left) and **Forrest W. Swisher** a mire the tilt table made by Dr. **P. D. Mozley.**

and **2.** The exhibit hall fills with physicians during the ientific sessions' recesses for coffee. **3.** Drs. **Benjamin H. loes, Jr.,** and **David L. Sarrett** converse prior to the rginia Ob-Gyn Society luncheon. Beyond the window, e autumnal sunshine lights up Williamsburg's charming ildings and profuse foliage. **4.** One of the tables at the merican College of Physicians luncheon. Clockwise m VIRGINIA MEDICAL Editor **W. T. Thompson, Jr.,** in ofile at right: Drs. **Wyndham B. Blanton, Jr., Robert K. addock, David W. Scott,** Presiding Officer **Edward W. ook, Donald W. Drew, Walter P. Adams, John P. ynch, William H. Harris, Jr.,** and **Gilman R. Tyler. 5.** omen of the Auxiliary find their places for luncheon as r. **Hugh Warren** (far left) takes pictures.

3.



1.



4.



2.



5.



Ruptured Intracranial Aneurysms in Pregnancy

David L. Meincke, MD, W. Glenn Hurt, MD, and Harold F. Young, MD,
Richmond, Virginia

Ruptured intracranial aneurysms in the third trimester of pregnancy demand immediate diagnosis. A combined plan of obstetrical and neurosurgical management must be formulated to obtain optimal results.

DUE TO ADVANCES in the treatment of hemorrhage, infection and toxemia, ruptured intracranial aneurysm has gained increased relative importance as a cause of maternal morbidity and mortality. During the years 1955-1960, at St. Joseph's Infirmary in Atlanta, intracranial hemorrhage accounted for 80% of maternal mortality.[1] In Virginia, there was one maternal death due to intracranial hemorrhage in 1973 and three in 1974. Two pregnant patients with subarachnoid hemorrhage secondary to documented ruptured intracranial aneurysms were treated at MCV in 1974 and 1975 and their histories are presented.

CASE REPORTS

Case 1.

A 26-year-old black female was admitted to the obstetrical emergency room of the Medical College of Virginia on January 6, 1974. The patient had been found by her husband in the bedroom of their home lying unconscious on the floor. There was no history of major medical illness or complications of the patient's present pregnancy.

Physical examination on admission showed her blood pressure to be 100/60, her temperature 100.2°F, respirations 30 and pulse 92. She was very lethargic but did respond to verbal stimuli. Examination of the head revealed no evidence of trauma. Neurological examination was reported to be normal except for the patient's lethargy. Abdominal examination revealed a gravid uterus of 37 weeks gestational size with a fetal heart rate of 144. She was given 5% dextrose in water intravenously and a Foley catheter was inserted. Fifty milliliters of 50% glucose was given intravenously with no change in the patient's mental status.

Admission laboratory work showed a hemoglobin of 11.1 gm% and a white blood cell count of 10,100. Electrolytes were normal except for a CO_2 of 15 meq/1. BUN and blood glucose were normal as was her chemistry screen.

The patient showed no improvement after six hours of hydration. Her blood pressure had risen to 160/100 during this period and although eclampsia was considered as a possible diagnosis, a neurology consult was obtained.

Examination by the consulting neurologist revealed nuchal rigidity. A lumbar puncture showed grossly bloody cerebrospinal fluid, with an opening pressure of 310 mm of water. Emergency arteriography revealed a left posterior communicating artery aneurysm (Fig. 1). The patient was placed on complete bed rest and given dexamethasone sodium phosphate to control cerebral edema. After nine days, her mental status had improved and she was considered ready for intracranial surgery. On January 15, 1974, a low transverse cervical cesarean section and bilateral partial salpingectomy were performed with delivery of a 6-lb 3-oz female infant whose Apgar at 1, 2 and 5 minutes was 8-9-10. Under the same anesthetic, a craniotomy was done with clipping of the left posterior communicating aneurysm. Postoperatively the patient again became very lethargic and was aphasic. She developed deep leg vein thrombophlebitis, which responded to treatment, and was discharged from

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Fig. 1, Case 1. Left, preoperative arteriogram demonstrating left posterior communicating artery aneurysm (arrow). Right, postoperative arteriogram after aneurysm has been clipped (arrow).

the hospital Feburary 9, 1974. She was readmitted to the hospital two days later having suffered pulmonary embolization from which she recovered uneventfully and is now ambulatory but with residual dysphasia.

Case 2.

A 38-year-old white female was admitted to the emergency room of the Medical College of Virginia on March 12, 1975. Six weeks prior to her admission she had been treated in the referring hospital with bed rest and sedation for high blood pressure. She had developed a headache the morning of admission, took an unknown medication and returned to bed. A neighbor with her at the time observed her fall to the floor on rising from bed. She was taken by ambulance to her local hospital where she was found to be very lethargic and immediately transferred to MCV.

Physical examination on admission showed an obese, unconscious female with labored respirations. Blood pressure was 165/94 and pulse 114. Neurological examination showed the right pupil dilated and larger than the left. She demonstrated decerebrate posturing to noxious stimulation. Doll's eye movements were present on head rotation. Abdominal examination showed a gravid uterus of 32-34 weeks gestational size with a fetal heart rate of 140.

A central venous pressure catheter was inserted and 5% dextrose and water begun intravenously. The patient was intubated and a Foley catheter inserted. Because of clinical signs of increased intracranial pressure, a twist drill ventricular tap was performed and revealed bloody cerebrospinal fluid. Bilateral carotid arteriography demonstrated a right middle cerebral artery aneurysm with a large temporal lobe mass lesion effect (Fig. 2). She received 500 milliliters of 20% mannitol to acutely reduce intracerebral pressure as she was being prepared for surgery.

Approximately two hours after admission to the hospital, the patient was taken to the operating room where a



Fig. 2, Case 2. Left, preoperative arteriogram demonstrating right middle cerebral artery aneurysm (arrow) with a large temporal lobe mass lesion effect. Right, postoperative arteriogram after the aneurysm has been clipped (arrow) and hematoma evacuated.

cesarean section and bilateral fimbrectomy were performed with the delivery of a viable 2-lb 11-oz infant. Under the same anesthetic, a right temporal craniotomy was done with the evacuation of a large temporal hematoma revealing the bleeding aneurysm, which was clipped. Postoperatively the patient recovered consciousness but retained a left spastic hemiparesis. The infant had mild respiratory distress but did well and was discharged from the hospital weighing 4 lb 10 oz. By September, 1975, the patient was functioning well mentally, but had a severe spastic paresis of the left arm.

DISCUSSION

Morgagni first described an intracranial aneurysm in 1762,[1] and Gerin-Rose, in 1859, reported the first case of subarachnoid hemorrhage in pregnancy.[2] Eppinger proposed a developmental defect in the vessel wall as the cause of berry aneurysms in 1887, and in 1930 Forbus demonstrated a medial defect.[3] Few cases of ruptured intracranial aneurysm were reported until after World War II when cerebral arteriography, developed in 1927 by Moniz, became popular.

Subarachnoid hemorrhage is the most common cerebrovascular complicaton occurring in pregnancy, but the actual incidence is difficult to determine due to the frequency of incorrect diagnosis.[3] The autopsy incidence of unruptured intracranial aneurysms in the general population is 0.5-1.0%, which would put approximately 20,000-40,000 pregnant women at risk yearly, yet only 127 cases of documented ruptured intracranial aneurysms during pregnancy have been reported.[4] The incidence at any given institution tends to depend on the interest its neurosurgical unit has in the problem, and reports vary from 1 in 2700[5] to 1 in 8070[6] deliveries.

That the incidence of rupture of intracranial aneurysms increases with the duration of pregnancy has been shown by several authors. In Hunt's review of 127 patients reported by various authors, he found 6% occurred in the first trimester, 33% in the second trimester and 55% in the third trimester.[4] Rupture of an intracranial aneurysm was a rare finding in labor. Robinson added 14 cases to the literature and found a combined incidence of 10% in the first trimester, 26% in the second and 59% in the third trimester. He pointed out that since cardiac output rises early in pregnancy and tends to plateau, the increased incidence of rupture in late pregnancy might in some way be related to increased blood volume which tends to increase at a similar rate.[7]

The most common presenting symptom of ruptured or leaking intracerebral aneurysm is headache, which is often accompanied by neck stiffness and occasionally by nausea and vomiting. Depression of the sensorium is often seen and coma is observed at some point in approximately 50% of patients, although it is a presenting symptom in only 10%.[8] Aphasia and focal signs of weakness, paralysis, or sensory loss may be seen.

The most common physical finding is nuchal rigidity, which is observed in 50% of patients. Mild hypertension is seen in approximately 10% and moderate hypertension in 40% of patients after aneurysm rupture. Hemianopsia and hemiplegia are found in 10% of patients and papilledema is an occasional finding.

The main problem in differential diagnosis is confusion with eclampsia. The key to the diagnosis, however, is the spinal tap. In eclampsia, the fluid is normally clear and has a normal pressure whereas in ruptured intracranial aneurysm, the fluid is grossly bloody and has an increased pressure.

When subarachnoid hemorrhage is diagnosed, the etiology is determined by cerebral arteriography. Complete arteriography should be performed immediately to locate the aneurysm and to demonstrate any mass lesion needing evacuation.

Initial management of ruptured intracranial aneurysms is directed toward establishing a good airway in the comatose patient and fluid replacement. That surgical treatment is mandatory was shown by Trumpy, who reported a 70% incidence of recurrent hemorrhage in patients treated conservatively.[9] Hunt and Hess have shown that, in general, morbidity and mortality of patients with demonstrated aneurysms undergoing operation are closely related to the clinical condition of the patient at the time of surgery. The better the patient, the better the result from the operation to obliterate the aneurysm.[10] Thus, if possible, patients with subarachnoid hemorrhage from aneurysms should be allowed to recover from the ictus of their hemorrhage until their neurological condition is normal. As an ideal, the neurosurgical management of the cases should be carried out as it would have been were the patient not pregnant. Dexamethasone sodium phosphate has been used to acutely reduce elevated intracranial pressure until surgery can be arranged to evacuate any mass lesion. Although useful in nonpregnant patients, mannitol is probably contraindicated in the pregnant patient as it has been shown in animal studies to cause a flow of water from the fetus to the mother.[11] During surgical obliteration of aneurysms, hypothermia has been used successfully. Poole reported its use in 11 pregnant patients with no adverse fetal effects.[12] Hypotension has also been employed during surgery but excessive fetal movement and deceleration of the fetal heart rate have been observed, indicating that hypotension should probably be avoided.[12,5] The operative

mortality from surgery to obliterate intracranial aneurysms is 1-10%.

The obstetrical management of patients with ruptured intracranial aneurysms is not as clear cut as the neurosurgical management. Until recently, the most commonly recommended management was elective cesarean section. Amias, however, found no difference in mortality in his group of patients, eight of whom were delivered by cesarean section and four by the vaginal route, following surgical obliteration of the aneurysm, and neither did he find any advantage to the infant. Botterell had no mortality in his four patients delivered vaginally following surgical therapy of the aneurysm.[5] He feels cesarean section may be indicated when the aneurysm is inaccesable to surgery or if the bleeding occurs immediately prior to or during labor. Hunt, however, reviewed the literature and found 30 patients who had cesarean section, seven of whom had a recurrent hemorrhage. Six of the seven with recurrent hemorrhage had not been treated surgically. In a group of 56 patients delivered vaginally, there were also seven cases of recurrent hemorrhage, and it was their conclusion that cesarean section held no advantage whether or not the aneurysm had been treated surgically. The authors agree that cesarean section offers no advantage in the patient who goes into spontaneous labor whether the lesion has been corrected or not.

We feel that cesarean section is indicated in the moribund patient with a proven aneurysm and a viable fetus, as the maternal prognosis in this incidence is extremely poor. The main area of controversy would seem to be the patient at term with a documented ruptured aneurysm who is stable and ready for surgical correction of her aneurysm, as in the first case presented. Although treatment must be individualized, we feel the morbidity from elective cesarean section in these patients may be less than having the patient go into spontaneous labor soon after neurosurgical correction of the aneurysm, when she may have increased cerebral edema and be in worse condition than she was preoperatively. Unfortunately, the number of cases is too small to document this viewpoint.

The mortality from ruptured intracranial aneurysm in pregnancy parallels that in the nonpregnant and is about 40%. Recurrent hemorrhages are fatal in 60%. The level of consciousness at the time the patient is first seen seems to be the best prognostic factor. Richardson states the mortality is 27% in the alert patient, 55% for the drowsy, 71% for the stuporus and 90% for the comatose.[13]

In summary, two patients with intracranial aneurysms which ruptured during the third trimester of pregnancy are presented. The key to diagnosis is the spinal tap, which differentiates ruptured intracranial aneurysm from eclampsia, the most common misdiagnosis. Arteriography should be performed immediately when the diagnosis of subarachnoid hemorrhage is made and will demonstrate the lesion in 90% of cases. The neurosurgical management should consist of immediate surgery if there is evidence of a mass lesion and delayed surgery until the patient has recovered from the ictus of hemorrhage if there is no evidence of a mass lesion. Obstetrical management must be individualized, but in general, vaginal delivery with epidural anesthesia is preferable. Cesarean section is indicated in moribund gravidas with a mature fetus due to the high maternal mortality and may be acceptable in patients at term who are not in labor and are ready to undergo surgical obliteration of their aneurysm.

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Subcutaneous Arteriovenous Fistula for Hemodialysis

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Creation of a subcutaneous arteriovenous fistula provides simple, safe access to hemodialysis in patients with end-stage renal disease. It is well accepted by patients, medical staff and dialysis personnel.

HEMODIALYSIS is the standard life-saving procedure for patients with end-stage renal disease (ESRD) awaiting suitable donors for renal transplantation. At 476 centers in the United States, 13,708 patients were maintained on hemodialysis as of April, 1975.[1] Maintenance on long-term hemodialysis necessitates the availability of a blood vessel easily accessible for percutaneous cannulation.

In 1960 Quinton et al[2] introduced a method of external arteriovenous shunts by cannulating the radial artery and a forearm vein with teflon tubings. Although this method has prolonged life for many uremic patients, a considerable number of complications related to the prosthetic cannulas have been noted. These complications include local thrombosis, infection, bleeding, erosion of the skin and dislodgment of cannulas.[3] Due to the complications associated with this method, Brescia and his associates[4] described in 1966 the technique of creating a subcutaneous arteriovenous fistula between the radial artery and cephalic vein in the forearm to allow percutaneous cannulation of the arterialized vein.

This paper reports our 40-month clinical experience with arteriovenous fistula constructed in patients with end-stage renal disease in the Salem VA Hospital dialysis program from September 1972 through January 1976.

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MATERIALS AND METHODS

The charts of 59 consecutive end-stage renal disease patients with arteriovenous fistula were reviewed. Arteriovenous fistula procedures totalling 98 were constructed. Thirty-one patients (53%) had a single or primary A-V fistula; the remaining 28 patients (47%) had 67 secondary A-V fistula constructed. There were 52 males and seven females. Forty-three were veterans and 16 were nonveterans. The age range was from 11 to 73 years; the average age was 46 years. The indications for hemodialysis were end-stage renal disease due to chronic glomerulonephritis, nephrosclerosis, chronic pyelonephritis, polycystic kidneys and, in half the cases, unknown causes.

SURGICAL TECHNIQUE

Surgical arteriovenous fistulas were constructed on the nondominant forearm under local or regional block anesthesia utilizing standard vascular techniques.

The initial anastomosis between the radial artery and vein was done at the area of the wrist using the side-to-side, end-to-end or end-to-side anastomosis, depending on the character and availability of the blood vessels. When a suitable artery or vein was not available at the wrist for anastomosis, the fistula was constructed at the cubital fossa. The anastomoses

between the brachial artery and cephalic vein, interposition of an autologous vein or bovine graft between a suitable artery or vein, were done when the more conventional procedures were not feasible. Continuous 6-0 or 7-0 nonabsorbable synthetic suture material was used for the vascular anastomosis. At the completion of the procedure, the anastomotic patency was checked by palpation of a bruit or the use of a doppler ultrasound. The fistula was allowed to mature three to four weeks before cannulating the vein, to insure intimal covering of the suture line and dilation of the vein.

TYPES OF A-V FISTULA

The following vascular anastomoses were constructed (Figure 1):

- Side-to-side radial artery to cephalic vein,
- End-to-side cephalic vein to radial artery (end of vein side of artery),
- End-to-end radial artery to cephalic vein,
- Side-to-side brachial artery to cephalic vein,
- Interposed loop-autogenous saphenous vein between the brachial artery and cephalic vein (end-to-side),
- Bovine grafts interposed between the brachial artery and axillary vein as a straight graft or as a loop between the brachial artery and cephalic vein.

RESULTS

The patency rate of each A-V fistula procedure done during the 40-month period is shown in Figure 2.

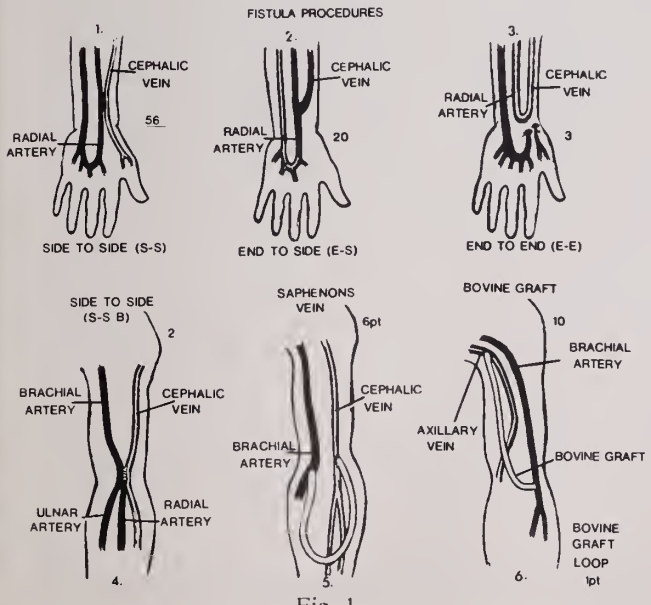


Fig. 1.

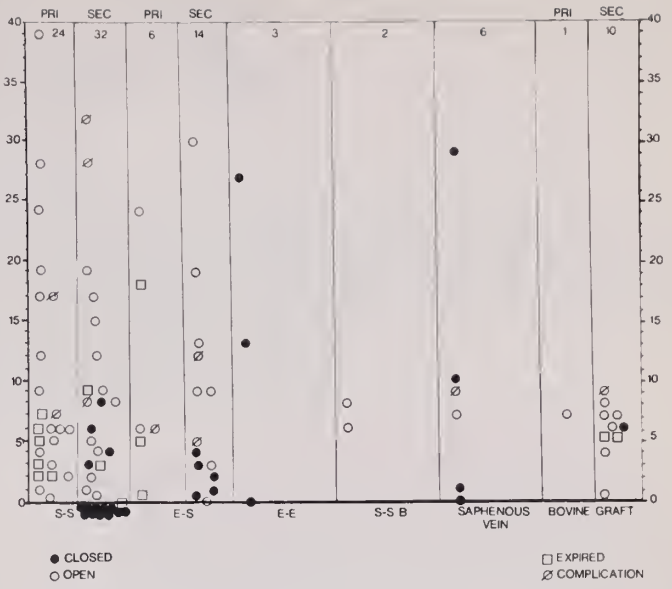


Fig. 2. Patency of arteriovenous fistula. Closed circles indicate thrombosed fistulas; open circles patent fistulas. Squares represent patients who died with open fistulas. Slashed circles denote fistulas with complications.

Thirty-one patients had primary (Pri) or single arteriovenous fistulas, while 28 required 67 secondary (Sec) or multiple procedures.

The primary side-to-side (S-S), end-to-side (E-S), and bovine grafts in 31 patients were patent for two weeks to 39 months. Sixty-one percent had patent fistulas after five months, and 71% are alive and undergoing hemodialysis.

The secondary S-S, E-S, E-E, side-to-side brachial artery-cephalic vein (S-SB), saphenous vein and bovine grafts were patent for two weeks to 32 months in 28 patients. Of 67 A-V fistula procedures, 25 (37%) were patent after five months. Twenty-three patients (82%) in this group are alive and undergoing dialysis. Early failure was observed in 15 (22%) of 67 procedures.

Of the subcutaneous A-V fistulas documented in this study, 46 (47%) remained patent, while 28 (28.5%) closed. Ten of 98 procedures (10.2%) developed nonthrombotic complications, treated successfully. Fourteen patients (14.3%) died from conditions not related to the fistula.

COMPLICATIONS

Thrombosis of the arteriovenous fistula was the most common complication in 31 (31.8%) of 98 procedures. Eighteen fistulas (18.4%) thrombosed early because of the following reasons: 1) poor quality and caliber of the peripheral arteries due to arteriosclerosis or calcification, especially in diabetic

patients; 2) the lumen of the veins were small and would not dilate even with intraluminal saline injections; 3) kinks or advential bands narrowed the vein.

Late thromboses in 13 procedures (13.4%) were attributed to the following: 1) intimal flap caused by percutaneous cannulation of the arterialized vein; 2) hematoma around the vein; 3) obstruction of the vein by tight compression or tourniquet at the venopuncture site following hemodialysis. Four late fistula thromboses were successfully treated with Fogarty balloon thrombectomy.

Pseudoaneurysm developed in six A-V fistula procedures (6%), four at the venopuncture sites and two at the region of the anastomosis. These pseudoaneurysms were successfully excised. Flow was reestablished and the fistulas remained patent.

Infection of the bovine graft occurred in one patient after scab removal at the venopuncture site. This graft subsequently bled and had to be removed.

Massive hemorrhage from the saphenous vein graft occurred after scab removal at the cannulation site. The vein was repaired and the fistula functioned for another three months.

One patient developed edema, stasis dermatitis, hyperpigmentation and ulceration of the hand similar to that of lower extremity venous insufficiency. The edema, dermatitis and ulceration improved by elevating the hand.

Fatal pulmonary embolism occurred following construction of a loop-saphenous vein graft A-V fistula between the brachial artery and cephalic vein. The origin of the embolus was presumably thrombophlebitis in donor's leg. This was the only mortality related to the A-V fistula procedures.

COMMENT

At the end of the study period, 45 patients (68%) were alive with functioning A-V fistulas. These patients were hemodialized three times a week either at their homes, at satellite units or at the VA Hospital. Half of these patients did their own venopuncture. The arteriovenous fistulas of these patients were used as dialysis access 6,664 times. Four patients underwent renal transplantation. Only one was successful, and the other three patients were returned to hemodialysis.

Eleven patients with arteriovenous fistulas did not undergo hemodialysis since they were doing very well on peritoneal dialysis. When peritoneal dialysis failed in two patients, A-V fistula was immediately available.

Arteriovenous fistulas were well accepted by the patients. The morbidity related to these procedures was considerably less than shunts.[5] Although it is recognized that large A-V fistulas have significant hemodynamic effect on the heart, we did not observe heart failure related to the A-V fistulas even in patients with 15-mm anastomoses.[6]

Another serious complication of A-V fistula is neurovascular ishemia. Haimov et al[7] reported 1.6% incidence, particularly when bovine graft was used at the brachial or axillary artery level. To avoid this, he suggested measuring the blood flow and limiting it to 400-500 cc/minute. Another way was to narrow the size of the anastomosis in proportion to the caliber of the distal artery.

We preferred the conventional arteriovenous fistula at the distal forearm because it is simple, easy to construct, well tolerated and offers fewer complications. Furthermore, the patency rate is longer and the patients have an easier time cannulating their arterialized vein. The alternative methods of arteriovenous fistula were used following shunt or fistula failure.

SUMMARY

Arteriovenous fistula is now an accepted method of vascular access for hemodialysis in chronic end-stage renal disease. The arteriovenous fistula constructed is based on the status of the forearm vessels. Our results were satisfactory and comparable to other dialysis centers.[8]

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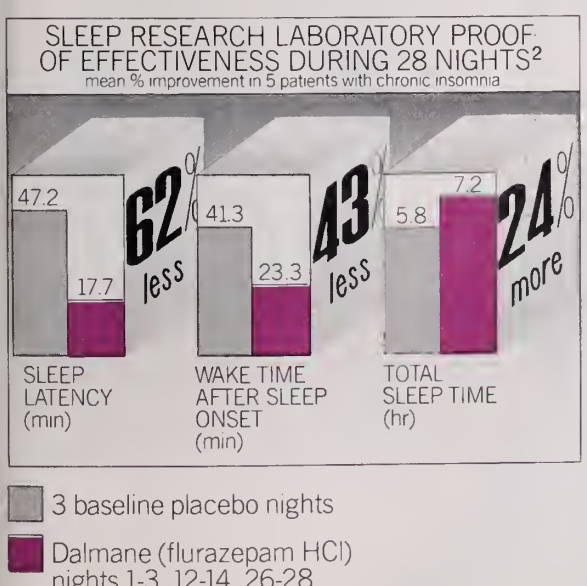


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***Usage in Pregnancy:* Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

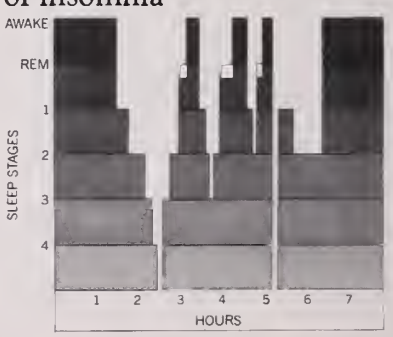
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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Perforated Gastric Ulcer Secondary to Gallstone Ileus

John E. Reed, MD, Wyatt Beazley, MD, and S. Elliott Oglesby, MD,
Richmond, Virginia

An unusual case of acute gastric ulcer secondary to gallstone ileus is reported, and the authors review other complications of biliary-enteric fistulas.

THE FIRST article dealing with cholecystointestinal fistulas was recorded in 1654 by Bartholin.[1] The first article dealing comprehensively with the subject was published in 1890, a collection of 131 cases.[2] At the time of the classic article on gallstone ileus by Deckoff[3] in 1955, a total of 555 cases had been reported. Approximately 700 had been reported in the surgical literature by 1970.[4]

The diagnosis of gallstone ileus has the roentgenographic features described in the classic article of Rigler[5]: 1) air in the biliary tree; 2) direct or indirect visualization of a stone in the bowel lumen; 3) change in position of a previously noted gallstone; 4) roentgenographic evidence of partial or complete intestinal obstruction.

The following is a case of gallstone ileus with the original radiographs showing a large gallstone in the right upper quadrant with subsequent development of a gallstone ileus, meeting the criteria of Rigler as listed above. In addition, an associated complication not previously noted in the literature is described.

CASE REPORT

This 74-year-old female was first admitted to Stuart Circle Hospital on January 8, because of a three-week history which included two episodes of epigastric pain associated with nausea and vomiting. Pertinent findings on admission revealed a plain film of the abdomen demonstrating a 2-cm × 3-cm gallstone in the right upper quadrant (Figure 1). The upper gastrointestinal series was normal (Figure 2). The patient declined surgery for the gallstone and was discharged on January 16.

The patient was readmitted on February 11, having a three-day history of severe cramping abdominal pain and vomiting of fecaloid material. She was admitted in a hypothermic (96° F), hypotensive (80/60) condition. She had an irregular pulse of 130 beats per minute. She was pale, shocky and had an acute surgical abdomen. Laboratory studies revealed a white blood cell count of 9,000/cu mm with a shift to the left, hemoglobin 17 gms% and a BUN of 50 mg%. Plain abdominal radiographs on this second admission showed: 1) air in the biliary tree; 2) signs of small bowel obstruction; 3) The stone noted on the previous admission in the right upper quadrant was now in the right lower quadrant (Figure 3); 4) the finding of free intraperitoneal air under the diaphragms (Figure 4).

The patient was diagnosed as having a gallstone ileus with a perforated viscus, site undetermined. She underwent immediate exploratory laparotomy and the gallstone was removed from the terminal ileum. In addition an acute, perforated gastric ulcer was found. This was thought to be a "stress ulcer." The ulcer was excised and the stomach closed.

Her postoperative course was complicated by cardiac arrhythmias, hypotensive episodes, and acute renal failure. The patient expired on the fifteenth hospital day.

DISCUSSION

An extensive review of the literature shows many complications of biliary-enteric fistulas, such as jaundice, cholangitis and gastrointestinal hemorrhage. The fistulas may extend from the gallbladder to the bronchial tree, pericardium, hepatic artery, portal vein, ovary, renal pelvis, vagina, bladder, uterus or small bowel.[6] Another complication of gallstone ileus has been recurrences.[7–10] There have been several

From the Department of Radiology (Dr. Reed), Department of Surgery (Dr. Beazley) and Department of Family Practice (Dr. Oglesby), Stuart Circle Hospital, Richmond VA 23220.

Submitted 11-26-75.



Fig. 1. The preliminary film before upper gastrointestinal series shows a 2-cm. × 3-cm. solitary gallstone in the right upper quadrant.



Fig. 3. The x-rays from the second admission show free air under the diaphragm.



Fig. 2. The upper gastrointestinal series was normal with no evidence of ulceration.



Fig. 4. There is air in the biliary tree and the small bowel is moderately dilated. The gallstone has now moved to the right lower quadrant.

cases of gallstone impaction of the colon reported.[11-13] Other rare complications associated with gallstone ileus are bacterial enteritis proximal to the obstruction,[7] gallstone impacted in the stomach and duodenal bulb[14] and perforation of the small bowel at the site of stone impaction.[15]

Acute gastric ulcer (probably a "stress ulcer") in association with and probably secondary to gallstone ileus has not been described previously. The diagnoses in this case are confirmed by recent films of the abdomen, recent normal upper gastrointestinal series and the subsequent development of a gallstone ileus and perforated gastric ulcer, confirmed roentgenographically and at surgery.

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CME: The Goal, Improved Patient Care

William F. Bernart, MD, *Nassawadox, Virginia*

"... A positive philosophy about CME may provide the antidote for the cynicism that has permeated American medicine ..."

CONTINUING MEDICAL EDUCATION: what does this concept mean to the practicing physician in Virginia? It is part of a growing phenomenon in medicine, the need for ongoing medical training, review of old concepts and the desire to understand and utilize the rapidly developing technological changes in medical practice. The primary goal of CME is to improve patient care.

This sudden need for CME is motivated by one prominent factor. The enlightened public is, unfortunately, swelling the courts with malpractice litigation. As a defensive measure, medicine is attempting to develop methods for weeding out incompetent practitioners. However, if we can develop a CME program to improve patient care as an ongoing experience, then the results will be obvious to us and to the society which we strive to serve.

This pressure has resulted in political decisions in 12 states: medical practice acts now require evidence of CME as a condition for relicensure! The Medical Society of Virginia, realizing this urgent need, established four years ago a Commission on Continuing Medical Education and charged it with a mandate for developing the techniques for the accreditation of medical organizations and for the certification of its individual member physicians. The Medical Society of Virginia is considering by-laws and charter changes requiring CME credits as a prerequisite for membership commencing in January, 1977. Most physicians have some familiarity with the Physician's Recognition Award of the AMA; 150 credits, derived from various educational categories, are required during a three-year period for this award. The Commission on CME in Virginia has decided on two levels of awards: one will recognize the attainment of the AMA award, the second will be of a higher degree and will be The Medical Society of Virginia's own award.

It is evident to all physicians, particularly to those in primary practice, with its irregular hours and pressures, that "keeping up" with the constant technological changes in medicine has become an all but impossible task. Where and how can the busy practitioner find the time? How can he be motivated to review important clinical advances and diagnostic techniques? He must, in this climate of malpractice litigation, realize the necessity to develop, perhaps, a new "life style"—a CME philosophy—a way of life! He cannot approach CME with a negative attitude. Compulsory attendance, or "signing in," can be circumvented! It must not be solely an "R & R" (rest and relaxation) experience away from home. It can be a *positive* motivator in our search for better patient care. As Dr. George Miller of the University of Illinois College of Medicine recently stated, CME must encourage physicians to become "lifetime learners rather than perpetual course-takers."

How can these 150 credits be amassed in the short span of three years? Can the busy physician obtain them close to home? As one harassed rural practitioner put it "Wow, those credits will cost me $100 apiece!" He was referring to the time away from his office and to the cost of travel to the large medical centers, often several trips a year. This effort could be distastefully costly. However, through the stimulus of

h Commission on CME, approximately 110 hospitals in Virginia, plus the numerous health organizations, must serve as a catalyst for this ongoing educational need. Fortunately, the commuting distance to the local hospital or component medical society's meeting is less than an hour for most.

But will the physician attend CME conferences with a positive attitude? Yes, if the subject matter has pertinent application to his practice; yes, if the instructor is well versed in his subject; yes, if there is audience participation; yes, if he has an opportunity to select the subject matter on occasion and to criticize presenters in their techniques. No, if he is lulled to sleep by endless slides in a darkened room or chagrined by poorly prepared, disinterested instructors.

Evidence of how CME can work and of how practical and stimulating programs can be developed was demonstrated during a recent site visit by a team from the Commission's Accreditation Committee to Roanoke Memorial Hospital. There an imaginative CME program has been going on during the past 12 years under the able leadership of Dr. Charles Crockett. Their program, along with those of other institutions in the state, plus the enthusiasm and leadership which has been provided by the three medical schools, offers a practical framework for the development of programs in all of our medical institutions.

CME needs a two-way dialogue between the CME director and the physician. How can the needs of the doctor be determined and then, in a practical and stimulating fashion, be presented to him? Needs assessment, or "What do I need to know, to relearn?" and "Which of my practice skills need to be upgraded?", can be determined in several innovative ways. They include medical audits of hospital charts, peer review and surveys of medical staff and practicing physicians. Ultimately we must develop a continuing practice profile: What is the physician actually doing in his office? What are his practical needs at that level? Should the next CME conference focus on the diagnosis and therapy of the pharyngitis or offer a slide presentation of the metabolic needs of the SA node? CME is an exciting concept, a stimulating time for Virginia medicine. A positive philosophy about CME may provide the antidote for the cynicism which has permeated American medicine—the fears of nationalization of our practices, the hassle with third parties and the foreboding shadow of malpractice litigation. Continuing Medical Education: Yes, we want to!

The Commission on Continuing Medical Education of your Society stands prepared to assist you and your CME director in this quest for medical education and the goal of improved medical care for our patients.

MEETINGS ABOUT MEDICINE

January

Allergy, sponsored by Department of Pediatrics, University of Virginia School of Medicine, *Charlottesville,* January 13. Office of Continuing Medical Education, Charlottesville 22901.

The Alton D. Brashear Postgraduate Course in **Head** and **Neck Anatomy,** sponsored by the Department of Anatomy in cooperation with the Division of Continuing Education, School of Medicine and School of Dentistry, Medical College of Virginia *Richmond,* January 17-20. Dr. Hugo R. Seibel, Department of Anatomy, Richmond 23298.

Neurosurgical Society of the Virginias Annual Meeting: The Homestead, *Hot Springs,* January 20-22. Program Chairman, Dr. D. Ferry, 213 McClanahan Street, SW, Roanoke VA 24014.

February

Renal, sponsored by the Department of **Pediatrics,** University of Virginia School of Medicine: *Charlottesville,* February 10. CME Office, Charlottesville VA 22901.

Regional Meeting, American **College of Physicians** with the Virginia Society of **Internal Medicine,** Old Town Holiday Inn, *Alexandria,* February 12. Edward W. Hook, MD, Philip T. Rodilosso, MD, and James M. Moss, MD, presiding officers. Box 237, Department of Medicine, University of Virginia School of Medicine, Charlottesville 22901.

McGuire Lecture Series, "**Immunology** Update," Medical College of Virginia, *Richmond,* February 12-13. Continuing Education Department, Box 91, MCV, Richmond 23298.

Annual Meeting, Virginia Chapter, American Academy of **Pediatrics,** *Williamsburg,* February 25-26.

Mid-Atlantic Section of the American **Urological** Society, sponsored by the Department of Urology, University of Virginia School of Medicine: *Charlottesville,* February 26. CME Office, Charlottesville VA 22901.

PUBLIC HEALTH

JAMES B. KENLEY, MD, Commissioner, Virginia State Department of Health

Action in Virginia on the Federal Health Planning Law

Mack I. Shanholtz, MD, *Richmond, Virginia*

TREMENDOUS POTENTIAL for changing health care activities is carried by the National Health Planning and Resource Development Act of 1974, enacted early this year as Public Law 93-641, amending the Public Health Act. Congress incorporated in the Act provisions for federal support to a new health planning organization to augment regional and state planning for health services, manpower and facilities and to provide financial assistance in the development of new resources to further the national policy. Each level of organization was given responsibility to carry out specific functions.

The first action in implementing the new law was to divide the United States into Health Service Areas, or regions for health planning. In Virginia there are five Health Service Areas, as shown on the map. The boundaries of these Areas are the same as those for PSRO regions, except in Southwest Virginia, where Scott and Washington Counties and the City of Bristol are to be part of the Tennessee planning region. The Governor of Virginia has appealed this boundary decision by HEW.

A nonprofit private agency in each Area wholly within the state has been given a conditional designation to perform required regional planning functions. As the map designates, these are in Charlottesville, Falls Church, Blacksburg, Richmond and Norfolk. Each of these agencies has received from HEW a funding grant for one year. Priority of effort will include organization, gathering of data on status of health care and delivery systems, initiation of development of the regional health plan and local review of Certificate of Need applications.

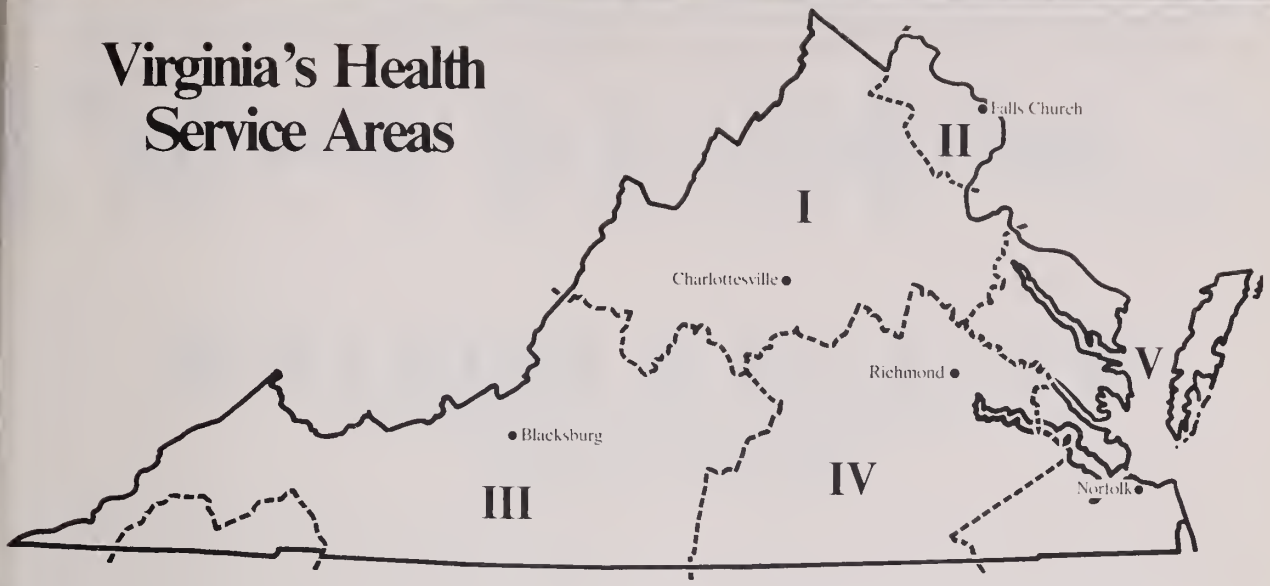
The federal, state and regional agencies are to coordinate their health planning and development efforts. Many of the regional actions and recommendations will be reviewed at the state level, where in most cases opinions will be passed on to HEW for decision.

Major functions which the state agency and council are to perform include: preparation of a state health plan, review of regional agency budgets, review from the state level of all applications for federal health-related funds, review of proposals to build new facilities for issuance of Certificate of Need, evaluation of existing institutional services to determine appropriateness of continuance and preparation of a medical facilities plan. Later, federal monies will be distributed to the state agency to be allocated as needed in the development or modification of health facilities: construction of new institutions in rural communities; modernization of old facilities in densely populated areas; development of outpatient services in rural and poverty areas; elimination of safety hazards in existing facilities and broadening the scope of care in some areas. In Virginia the Governor has designated the Department of Health as the state agency.

The National Council on Health Planning and Development is to have 15 members, including at least three persons who are also members of a state council

Dr. Shanholtz retired June 30, 1976, as Commissioner of the Virginia State Health Department.

Virginia's Health Service Areas



and three or more members from regional health planning councils.

To form the Statewide Health Coordinating Council, Governor Godwin appointed 32 Virginians, 16 of them providers, 16 consumers. It was required that 60% of these appointments follow recommendations of the Virginia Health Systems Agencies. These are the Council's members:

Providers

George E. Broman, Jr., MD, Culpeper
Lloyd B. Burk, Jr., MD, Arlington
A. L. Burkholder, South Boston
Nathan Bushnell, III, Roanoke
Mildred D. Gordon, Radford
Kenneth Haggerty, DDS, Arlington
William E. Holland, MD, Norfolk
Dale W. Lick, Virginia Beach
Patricia E. Lund, Burke
The Rev. A. F. MacCammond, Christiansburg
Roland L. Mason, Midlothian
Laura I. McDowall, Annandale
George P. Phillips, Williamsburg
Frank S. Royal, MD, Richmond
Thomas B. Stage, MD, Vienna
Malcolm Tenney, Jr., MD, Staunton

Consumers

Elizabeth D. Busbee, Rocky Mount
John W. Cain, Alexandria
Virginia A. Crockford, Richmond
John T. Hairston, Christiansburg
Dorothy Healey, Williamsburg
Rosa Hudson, Esmont
Margaret B. Inman, Alexandria
J. Rodney Johnson, Richmond
Harold A. Leet, Elkton
Anne M. Mason, Accomac
Leroy T. McAllister, Sr., Aylett
Robbie F. Owen, Wakefield
Jane C. Peery, Tazewell
Howard L. Sparks, Richmond
Joseph A. Tompkins, Montross
Amanda G. Vaughan, Portsmouth

How They Voted. . .

The HSA Act described on these pages came into being through the passage of Senate bill 2994 and House bill 16204. This is the way Virginia's congressmen voted on those bills.

Senators Byrd and Scott voted for passage of the Senate bill.

In the House, Satterfield (*3rd*), Daniel RWjr (*4th*), Daniel WC (*5th*), Robinson (*7th*) and Wampler (*9th*) voted for passage. Butler (*6th*) and Broyhill (*10th*) voted against passage. Downing (*1st*), Whitehurst (*2nd*) and Parris (*8th*) did not vote.

The Southwest Virginia Medical Society, with the help of Willard C. Osburn of the MSV staff, compiled these results and in a resolution voted to send letters asking for repeal of the HSA Act to the President, Virginia's congressmen and all those seeking election to office.

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The Medical Society of Virginia
PROCEEDINGS

Minutes of the Council

The Council considers malpractice countersuits, programs relating to health hazard appraisal and emergency medical services, complaints about Champus, proxy votes, amendments to by-laws and charter, and an addition to the headquarters building.

THE COUNCIL of The Medical Society of Virginia met in Richmond at the Regency Inn on Saturday, September 25, 1976.

These Council members were present: Dr. Raymond S. Brown, Dr. W. Leonard Weyl, Dr. Gervas S. Taylor, Jr., Dr. Harold L. Williams, Dr. Charles E. Davis, Jr., Dr. Charles M. Caravati, Jr., Dr. Gordon G. Birdsong, Dr. Girard V. Thompson, Sr., Dr. H. C. Alexander, III, Dr. George M. Nipe, Dr. Harry C. Kuykendall, Dr. James Hal Smith and Dr. C. Barrie Cook.

These also attended: Dr. Russell E. Herring, Jr., Dr. George E. Broman, Dr. Nicholas G. Colletti and Dr. Robert V. Gailliot, Vice-Councilors; Dr. William S. Hotchkiss and Dr. F. Ashton Carmines, AMA Delegates; Dr. John A. Martin, Dr. Carl E. Stark and Dr. Percy Wootton, Alternate AMA Delegates; Dr. James M. Peery, President, Virginia State Board of Medicine; Dr. James B. Kenley, Commissioner, State Board of Health; Dr. John R. Jones, Associate Dean, Medical College of Virginia; Dr. William R. Drucker, Dean, University of Virginia School of Medicine; Dr. Gerald H. Holman, Dean, Eastern Virginia Medical School; William R. Miller, Attorney, The Medical Society of Virginia; and Robert G. Stuart, Executive Secretary, VaMPAC.

Virginia Council on Health and Medical Care.

Dr. Jachin B. Davis, representing the Virginia Council on Health and Medical Care, reported that the organization was in great need of additional financial assistance. He pointed out that the Virginia Council is providing a great many services which the Society would have to carry on if the Council did not exist. This is particularly true where physician placement and health career activities are concerned. Dr. Davis went on to say that individual physicians are not contributing the way they should and that industry does not believe that the overall profession is truly supporting the Council. Brought out was the fact that a cut-back in services is imminent if the needed assistance is not forthcoming.

Several members of Council supported Dr. Davis and his request for additional funds and stated the Council was providing invaluable services to the people of Virginia. Since the Society's present annual contribution is $5,000, it was proposed to increase it to $7,500 for fiscal 1976-77. *A motion to this effect by Dr. Caravati was seconded and adopted.*

Emergency Medical Services.

An overall integrated program of emergency medical services has been called vitally important to the people of Virginia and Dr. John Thiemeyer, Chairman of the Facilities Task Force, the Governor's Advisory Committee on Emergency Medical Services, discussed how The Medical Society of Virginia could be of assistance. He mentioned that accidents are the main cause of death where children are concerned and heart attacks take the greatest toll of those over age 35. Dr. Thiemeyer proposed that the membership of the Society be informed about the program, particularly in the area of facility evaluation. He made it clear that the program is not

trying to regulate hospitals in any way and that its only interest is developing the very best emergency medical service program possible for all Virginians.

Dr. Thiemeyer expressed the hope that the Society would cooperate with his Committee in the mailing of explanatory material to the membership and also by cosponsoring a one-day seminar having to do with assessment of emergency care facilities and capabilities.

A motion by Dr. Weyl to support the Emergency Medical Service Program was seconded and adopted.

Assessment.

Since a second assessment of $20 has been directed effective January 1, 1977, the question of whether non-dues-paying members should be assessed has come up once again. It was reported that the 1976 assessment caused numerous questions on the point.

It was the consensus that the 1977 assessment should not be mandatory for non-dues-paying members. *A motion to this effect was seconded and carried.*

Some concern was expressed over the failure of a small percentage of the membership to pay their 1976 assessment, and the administrative staff was directed to comply immediately with Article IV, Section 4 of the By-Laws.

VaMPAC Board.

One of Council's annual responsibilities is to elect a VaMPAC Board of Directors. After considering a slate of nominees representing all districts, Council elected the following directors:

District Chairmen

1st: James R. Howerton, MD, Newport News
2nd William S. Hotchkiss, MD, Norfolk
3rd: Henry S. Spencer, MD, Richmond
4th: Arthur A. Kirk, MD, Portsmouth
5th: Girard V. Thompson, Sr., MD, Chatham
6th: Charles A. Young, Jr., MD, Roanoke
7th: Harvey D. Smallwood, MD, Charlottesville
8th: Thomas L. Lucas, MD, Alexandria
9th: George R. Smith, Jr., MD, Shawsville
10th: Michael A. Puzak, MD, Arlington

Members-at-Large

1st: Keith H. Wolford, MD, Hampton
Mrs. Harold L. Williams, Woman's Auxiliary, Newport News
2nd: Clarke Russ, MD, Virginia Beach
3rd: Harold I. Nemuth, MD, Richmond
Percy Wootton, MD, Richmond
4th: Charles H. Moseley, Jr., MD, Petersburg
5th: Gerald Crain Burnett, MD, South Boston
A. Epes Harris, Jr., MD, Blackstone
Mrs. Robert D. Keeling, Woman's Auxiliary, South Hill
6th: Edward Miller Bowles, Jr., MD, Covington
Mrs. William N. Gordge, Woman's Auxiliary, Roanoke
Edward J. Stoll, MD, Lynchburg
7th: James R. Sease, MD, Harrisonburg
8th: Albert T. Ventzek, MD, Fairfax Station
9th: William B. Waddell, MD, Galax
10th: Ira D. Godwin, MD, Fairfax
W. Leonard Weyl, MD, Arlington

Bicentennial Reception.

Medical Societies from the thirteen original colonies have been invited to cosponsor a gala reception in Philadelphia during the AMA Clinical Session. The cost to The Medical Society of Virginia would be approximately $100 per AMA Delegate, or a total of $300.

An Executive Committee recommendation that the Society cosponsor the reception was approved.

Special Funding Request.

The Society has received a special request that it provide such funding as might be required to permit Dr. Jack Woodside to remain in Richmond during the 1977 session of the General Assembly. The Executive Committee had considered the request earlier in the day and agreed that Dr. Woodside had done a wonderful job for the Society during the 1976 session of the General Assembly. While it hoped that some means could be found whereby Dr. Woodside could spend a good part of his time in Richmond during the 1977 session, it did not believe that the Society should establish a precedent for such funding. It was concerned that such action might well mislead many to assume that there is more than one official spokesman for the Society. That spokesman must, of course, always be the President.

After agreeing that official notice should be taken of the excellent work provided on the Society's behalf by Dr. Woodside, Council voted to accept the recommendation of the Executive Committee.

Prince William Resolutions.

Two resolutions having to do with schools of optometry and use of drugs by optometrists were referred to Council by the Prince William County Medical Society. It was agreed that although similar resolutions had been adopted in the past, *they should nevertheless be approved and sent to the House of Delegates.*

Annual Meetings of 1981 and 1983.

Although Norfolk's Omni International Hotel had been selected as a site for the 1981 Annual Meeting and Arlington's Marriott Twin Bridges for the 1983 session, no dates had been officially confirmed. Acting on the recommendation of the Executive Com-

mittee, Council voted to approve the dates of October 22-25 for the 1981 Meeting, and October 20-23 for 1983.

A question was raised concerning a story which had appeared in some papers concerning the Omni operation and its future. Dr. Davis explained that the story had been satisfactorily explained and that Omni was apparently the innocent victim of a controversy surrounding Norfolk Gardens. It was his opinion that Omni International would very likely live up to all expectations and promises.

Conference of Officers of Component Societies.

The Executive Committee reported that the special leadership Conference of Officers of Component Societies was all set for the following day, September 26. It was explained that although the conference would be devoted in large part to the issue of "unified membership", component society officers would have an opportunity to discuss other matters of interest and concern. Hope was expressed that all members of Council would stay over for the conference.

Health Hazard Appraisal.

Dr. Brown reported on a new and fascinating concept of health hazard appraisal presented to the Executive Committee by Dr. John R. Jones of the Health Education Advisory Committee, State Department of Health. It was explained that the concept does have the support of AMA and that it acquaints the patient with the strengths and weaknesses associated with his way of life. The program in no way interferes with the traditional physician-patient relationship. Its three main features are 1) data collection, 2) data analysis, 3) patient feedback.

It was the recommendation of the Executive Committee that the program be carried out on an experimental basis for a period of perhaps five years. It was brought out that the Advisory Committee wanted to make sure that it had some indication of the Society's support before proceeding further.

The Recommendation of Council was then approved.

Workshops for Medical Assistants.

An organization known as Practice Productivity, Inc. has, for several years, worked closely with medical societies in the South and Midwest. It presents a number of workshops each year designed especially for medical assistants. These workshops are normally presented under the sponsorship of the state medical societies. Four of the workshops will be held in Virginia this Fall: Alexandria, Norfolk, Richmond and Roanoke.

After some discussion, Council concurred with the Executive Committee's recommendation that no action be taken because of the short notice involved. Hope was expressed that an expression could be obtained from the American Association of Medical Assistants, Virginia Chapter.

Risk Management.

The Medical Society of Virginia is cooperating with the State Board of Medicine and Virginia Hospital Association in developing a program of risk management. This joint effort is at the direction of the General Assembly and will have considerable bearing on future legislation affecting the malpractice problem.

Dr. Weyl discussed the work of the joint Risk Management Committee in some detail, covering its recommended investigative procedure, legislative proposal to relate continuing education to relicensure, and mandatory reporting of physicians suffering from certain addictions, etc. He expressed concern over the fact that the continuing education issue continued to be promoted although the Society remains on record as being opposed to mandatory CME for purposes of licensure.

The matter of immunity was then discussed at length, particularly as it applies to those medical societies and committees which take disciplinary action against offending members. Although bills being proposed by the Risk Management Committee do contain immunity provisions, there was some doubt as to whether total immunity could ever be truly assured. It was recommended, however, that the matter of immunity for committees should be explored at once.

The importance of maintaining confidentiality came in for its share of discussion, and it was reported that legislation will be sought by the Board establishing specific safeguards for investigative information.

It was the consensus that all of the legislation proposed by the joint Risk Management Committee should be referred to the Legislative Committee along with a report of Council's thoughts and concerns. *A motion to this effect by Dr. Kuykendall was seconded and adopted.*

Charter Amendment.

Council was advised that certain amendments appear necessary to the Society charter if it is to conform with Virginia statute. The adoption of such amendments—along with amendments to the by-laws with reference to unified membership and continuing medical education—will first require a vote by the membership in order to establish a specific quorum for general meetings. Consequently, the use of proxies appears to be the only way to handle the situation.

Mr. Miller explained the procedure that has been suggested, including the necessity of having Council

direct that a proxy vote be obtained. There was considerable discussion, during which a question was raised as to whether the proxy could concern itself only with the quorum issue—and not with proposed amendments to the charter and by-laws.

Dr. Alexander and Dr. Birdsong both suggested motions which would utilize proxies of a limited or general nature. It seemed to be the consensus that members should have a choice of designating a delegate, alternate delegate, or any other member of the Society, as his or her proxy. Because of the many opinions expressed and the obvious importance of eliminating any confusion that might exist, it was agreed to withdraw all previous motions on the subject and begin anew.

Dr. Kuykendall then moved that a proxy be mailed to the membership based on a proposed amendment to Article VI, Section 2 of the By-Laws which would open general meetings of the Society to all registered members and guests and designate 150 voting members as a quorum. It would also prohibit voting by proxy. The motion was seconded. There was agreement that the Judicial Committee would serve as a Proxy Committee but that a delegate, alternate delegate, or other member of the Society could be designated as the proxy choice. *The motion was then adopted.*

A followup motion by Dr. Kuykendall directed that the same envelope containing the proxy also contain information to the effect that proposed amendments to the charter and by-laws will likely be considered by the House of Delegates during the 1976 Annual Meeting in Williamsburg. *The motion was seconded and carried.*

By virtue of the above actions, the Council has stated that (1) it is in the best interests of The Medical Society of Virginia that the proposed amendments to the Charter of the Corporation be adopted, and (2) that the Secretary of the Corporation is directed to submit these amendments to a vote at the Annual Meeting 1976, giving notice thereof to all members of the Society by mail not less than 25 nor more than 50 days before such date.

Champus.

A resolution recently referred to Council by the VaMPAC Board of Directors expressed dissatisfaction with the manner in which the CHAMPUS program has been conducted in Virginia. It also requested that the Society take such action as it might believe advisable.

Dr. Girard Thompson reported that much of the dissatisfaction stemmed from the CHAMPUS practice of notifying providers of changes long after they were actually made. This has caused much confusion where deductibles and the filing of claims are concerned. Other complaints have to do with delays in payment, methods of determining individual payments, failure to keep military personnel informed, etc.

Discussion brought out the fact that an AMA resolution had urged physicians to bill CHAMPUS patients direct. Also mentioned was a change in CHAMPUS policy which no longer assures the patient private care.

A motion by Dr. Thompson directing that an ad hoc committee be appointed to explore the problem and report its recommendations to the House of Delegates was seconded and carried.

Public Relations Report.

Mr. Ed DeBolt, special PR consultant of the Society, presented a brief progress report on a questionnaire recently sent to the membership. He was particularly pleased with the 50% response thus far, an excellent return by today's standards. The questionnaire has provided each member an excellent opportunity to make his thoughts known about future malpractice activities, legislative workshops, etc. Mr. DeBolt expressed the hope that the profession will achieve a united front by reaching general agreement on key issues of the day.

Bicentennial Medical Exhibit.

Council was advised that the Bicentennial Medical Exhibit, located at the Richmond Academy of Medicine, is encountering financial difficulties. The monthly cost of keeping a hostess on hand five days each week is $265.74, and additional funds must be appropriated if the exhibit is to remain open to the public through October.

It was pointed out that The Medical Society of Virginia had made an initial contribution of $2,000 and then contributed an additional $1,000 last spring. The largest contributor has been the A. H. Robins Company, which has made nearly $25,000 available for design and construction. Should the Society have to bear the total expense of keeping the exhibit open through 1981, an annual contribution of approximately $4,000 would be required.

There followed considerable discussion during which concern was expressed over the disappointment—particularly to A. H. Robins—surely to occur should the exhibit be closed. Dr. Wootton urged that the Society's appreciation be officially made known to Mr. Robins and his staff along with an explanation of why the Society has been forced to reevaluate its role in the exhibit. A suggestion was made that the exhibit be funded until at least the end of this Bicentennial year and that the advice of Dr. Warthen,

Chairman of the Society's Bicentennial Committee, be sought in the meantime.

A motion by Dr. Weyl to terminate the Society's participation in the Exhibit after January 1, 1977 was seconded and adopted.

Practice Guidelines.

Dr. Alexander discussed a mode of practice which has caused some concern in the Roanoke area. The situation involves a physician from another part of the state who provides certain services to female patients in the area. He reportedly maintains a "medical center" in Roanoke proper and has arranged with an indefinite number of physicians in the area to provide "back-up" care and assistance should such be needed in his absence.

The Roanoke Academy of Medicine has expressed concern over this type of practice and whether or not quality medical care can be maintained. It believes that Council should know all of the details and perhaps provide some helpful guidelines for such situations.

It was learned that the "medical center" is open one day each week. While the Roanoke Academy of Medicine considers back-up help essential, it has not been able to learn just who provides this service. The physician in charge has refused to reveal their identities and has expressed displeasure over the Roanoke Academy's request for such information.

It was brought out that the American College of Surgeons definitely frowns on this type of practice. Dr. Alexander also mentioned that the Ethics Committee of The Medical Society of Virginia feels that the identity of back-up physicians should be known. Some concern was expressed, however, that services such as those provided by the "center" were not available elsewhere in that part of the state. It was also learned that the Department of Health has no authority during the first three months of pregnancy. It is very interested, however, and does everything possible to make sure that adequate care is being provided.

It was agreed that the basic issue involves patient safety. *A motion by Dr. Weyl to refer the matter to the Ethics Committee for further study and recommendations was seconded and carried.*

Long-Range Planning.

Dr. Hotchkiss reported on the following matters considered by the Committee on Long-Range Planning at the direction of Council and/or the House of Delegates:

Council Retreat: The Committee's recommendation that no retreat be held this year was approved. It was agreed, however, that the President should have the prerogative of arranging a Retreat whenever he believes it advisable.

Conferences of Officers of Component Societies: The Committee believes that the President should be free to call such a conference whenever a need is indicated. The importance of maintaining effective communications was recognized.

Member Participation During General Assembly: Although a suggestion had been made that compensation be seriously considered for those physicians who are asked to come to Richmond and testify during the General Assembly, the Committee believed that such really is not necessary. It was pointed out that most members are quite happy and willing to serve the Society without concern for compensation. It was also agreed that it would be most difficult to draw an acceptable set of guidelines for such compensation as travel expenses, honorariums, etc.

Dr. Kuykendall differed with the Committee's feelings and moved to proffer some form of compensation to the physicians concerned. His motion was lost for lack of a second. Council then voted to approve the Committee's recommendation that compensation not be considered. Dr. Kuykendall requested that his negative vote be recorded.

Annual Meeting Extension: Dr. Hotchkiss reported that the Committee had no definite recommendation concerning the advisability of extending annual meetings by one day. Although it was agreed that the suggestion possessed merit, there was considerable doubt that such an extension would prove generally popular and feasible. The fact that annual meetings have already been scheduled through 1983 also poses something of a problem. No definitive action was considered necessary at this time.

President's Salary: It was the Committee's recommendation that a stipulated income for Presidents—in addition to their authorized expense accounts—should not be provided. It did believe, however, that the Finance Committee should be requested to consider the inflation factor when recommending the amount of the President's expense account for the coming year.

Dr. Kuykendall then moved that the President's allowance be increased sufficiently to include any and all legitimate expenses and that Society officers be proffered reimbursement for out-of-pocket expenses incurred in connection with their official duties. It was understood that AMA delegates and alternate delegates would be included. *The motion was seconded and carried.*

At this point Dr. Weyl questioned the practice of having the President attend annual meetings of neighboring state societies. The cost continues to mount

and it would appear that the practice deserves some study.

A Committee recommendation that a Past Presidents luncheon be held—beginning with the Annual Meeting in 1977—was considered favorably.

Speakers Bureau: A Committee recommendation that the establishment of an organized speakers bureau be referred to Mr. DeBolt as a possible PR project was approved.

Tort System: Council learned that changes in the tort system are being proposed all over the nation and that efforts are being made in some areas of the country to bring together representatives of interested groups for the purpose of discussing tort system reform. The Virginia Association of Professions was suggested as the organization to approach in this regard, and it was reported that Dr. Hill plans to discuss the matter with VAP officers.

Headquarters Building: It was learned that the Society now has $75,000 in its special building fund and that this might well be the time to proceed with the planned addition to the headquarters building. Should a second wing be added at the west end of the building, the cost will be $75-79,000. Seven additional offices would be provided on the upper level and a full size conference room on the ground floor. *A motion that the Society proceed with the construction was adopted, along with a request that it explore the possibility of enlarging the conference room to the maximum extent possible.*

Countersuits.

A recent action by AMA encourages state medical societies to provide assistance to those physicians wishing to initiate meritorious countersuits against lawyers and plaintiffs who file what appear to be frivolous and unwarranted professional liability suits. One member has already asked whether the Society will review the merits of a suit brought against him and evaluate it from the standpoint of a possible countersuit.

Dr. Davis called Council's attention to countersuits which have been successful thus far, an Illinois case being the best known. The idea is apparently catching on all over the nation and some state societies are planning to establish special funds for use in financing such actions. It has been reported that the number of frivolous suits have definitely declined in those areas where countersuits have been successful. Since there are those who feel that there might be some legal deterrent to countersuits in Virginia, it is considered most important for the matter to be explored and resolved as soon as possible. Dr. Davis indicated that a resolution will very likely be introduced in the House by Delegates from the Norfolk Academy of Medicine directing the Society to take the lead in setting up an effective countersuit program in Virginia. He stated that such a program might well include special funds for such purposes.

There being no further business, the meeting was adjourned.

Robert I. Howard, Secretary

Approved:
Raymond S. Brown, MD, President.

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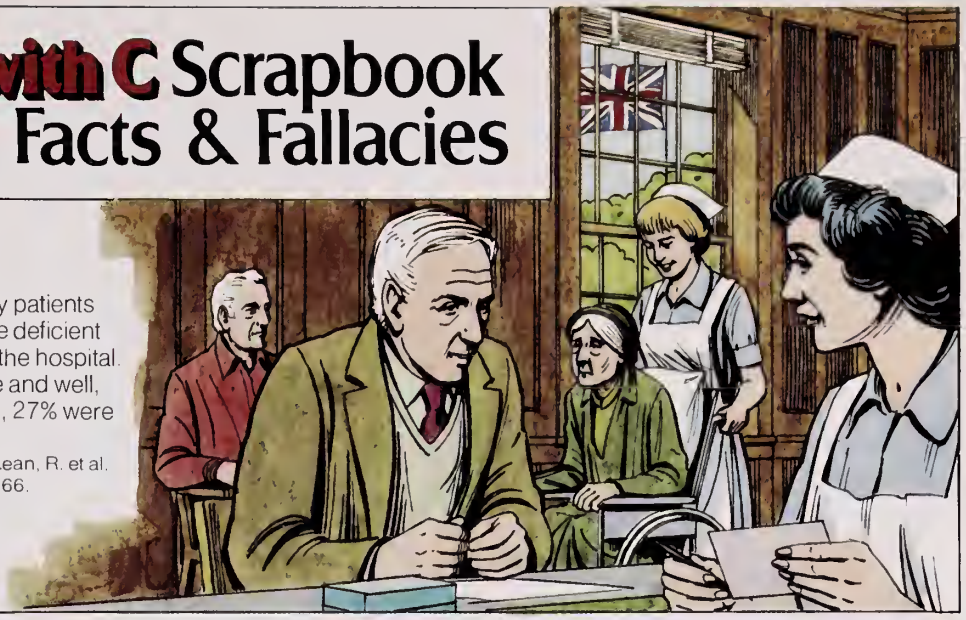
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Griffiths, L.L., Brocklehurst, J.C., MacLean, R. et al. *Diet in Old Age*, Brit. Med. J., 1:739, 1966.



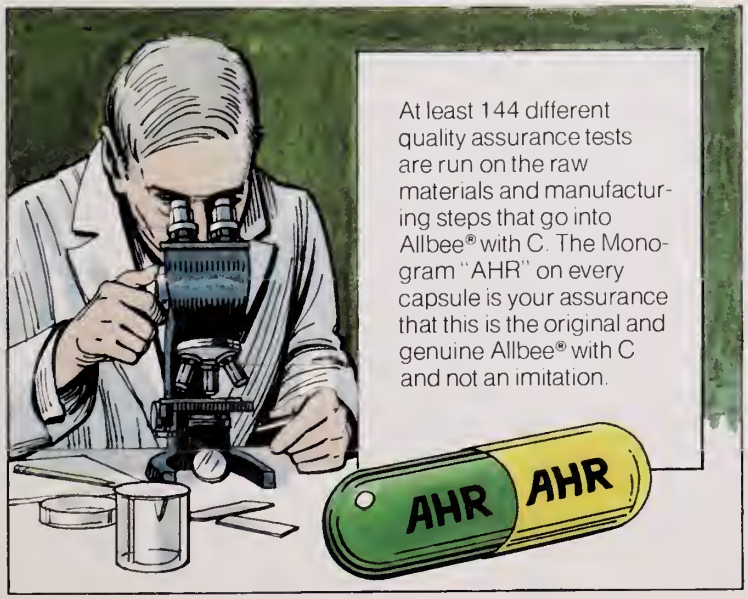
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VIRGINIA MEDICAL EDITORIAL

Dr. Weyl Brings a Distinguished History To the Presidency

THE NEW PRESIDENT of our Society is a general surgeon in Arlington and is dedicated to excellence in the practice of medicine. He is a reluctant "medical politician," coming to high office because this pursuit of excellence in troubled times seemed to call him. He is widely informed on a variety of subjects. He is a man of strong convictions and penetrating perception of problems.

W. Leonard Weyl, MD, was born in Frankfurt-am-Main, Germany, on May 28, 1921, of American parents, both of them physicians. His early education was both abroad and in the United States. He received an AB degree from Earlham College, Richmond, Indiana, and his MD degree from the University of Illinois School of Medicine, Chicago. Later he earned an MS in Surgery from Georgetown University. Upon graduation from medical school he served an internship at Herotin Hospital in Chicago. He then travelled the Pacific as a transport surgeon with the rank of captain. He left military service in 1948 to take a basic sciences course in surgery at the University of Illinois and then came to Georgetown University Hospital as a resident in surgery.

Dr. Weyl has been in the private practice of surgery in Northern Virginia since 1953. He is a diplomate of the American Board of Surgery, a fellow of the American College of Surgery, and a fellow of the Southeastern Surgical Congress. He is assistant clinical professor of surgery at Georgetown University School of Medicine and chief of surgery at Northern Virginia Doctors Hospital.

Len, as he is familiarly known, was president of the Northern Virginia Academy of Surgery in 1958. He has served several terms as editor of the *Medical Bulletin of Northern Virginia* and in 1972 was president of the Arlington County Medical Society. For The Medical Society of Virginia, he has been a first vice-president, a 10th district councilor and a member of the editorial board of the VIRGINIA MEDICAL MONTHLY. He has been vice-president of the Virginia Surgical Society and currently is vice-chairman of VaMPAC, vice-president and a director of the Northern Virginia Doctors Hospital and consultant to the health advisory committee of the Environmental Protection Agency.

In private life Len is known as an elder of the Georgetown Presbyterian Church, a Rotarian and a member of the Army-Navy and Farmington Country Clubs. His hobbies are sailing, photography and horsemanship. His sport is golf and he is a determined Wednesday afternooner.

Len is married to Nancy Schmidt Weyl, the daughter of a Presbyterian minister. Nancy is an artist of note with many shows to her credit. She is also an accomplished equestrienne who has placed high in two 100-mile cross-country events. Len and Nancy make their home in McLean, Virginia. They have two children: John Michael, 21, who is in Wilmington College, Ohio, with interests in agriculture; and Nancy Katherine, 18, who is in Colby College, Maine.

We congratulate Dr. Weyl on his past accomplishments and heartily welcome him as our President. He faces many difficult tasks, but he brings the talents to get them done. We wish him every success and pledge our utmost efforts in cooperation.

William L. Stone, MD,
Arlington, Virginia.



W. Leonard Weyl, MD, President, 1976-1977, The Medical Society of Virginia.

VIRGINIA MEDICAL EDITORIAL

1976: Salute to the Old Year

THIS TWELFTH-MONTH of Anno Domini 1976 seems to have arrived earlier than usual. But we have had a most eventful year, with bicentennial celebrations and election goings-on added to the usual duties, responsibilites, burdens and opportunities each of us has. Additionally, for those to whom it may have mattered, this has been a leap year.

Our 200th Fourth of July was properly recognized across the land as we noted with pride the progression of our country from a loose confederation of 13 Colonies to a world power of 50 closely knit states. It is humbling to realize, however, that we are less than half the age of the Roman Empire when it became senile and passed on; and a look at the many countries that have been preeminent for a time and are not so now gives us cause for sober reflection if not consternation.

How many of you visited the Bicentennial Medical Exhibit at the Richmond Academy of Medicine which was prepared by Dr. Harry J. Warthen and his staff? It is filled with delightful medical memorabilia of the Revolutionary era, including medical instruments, pictures, biographical sketches and a glossary of obsolete medical terms. Although the exhibit is now closed, it is not dismantled, and there is hope that it will be reopened in the spring.

On the whole, the elections demanded more attention than the birthday. To the surprise of some of us, the sun did rise as usual on the morning of the third of November, and even shone brightly for a part of the day. We are fortunate that Virginia returned a tested and competent delegation to Congress that will reflect for the most part the political philosophy of the doctors of Virginia.

From the rumblings that have come from the medical profession in Georgia, the same probably cannot be said about the election of Mr. Carter to the presidency. The doctors of the nation will await with keen concern the direction our government will take under the control of President Carter and a Democratic congress. The issues facing our profession will be even more critical in the future than they have been in the past. The most pressing will be the interrelated matters of national health insurance and the role of the federal government in the delivery of medical care.

Nearer to home, at the Annual Meeting of The Medical Society of Virginia in Williamsburg, Dr. Leonard Weyl succeeded Dr. Raymond Brown as President, and Dr. William Hagood was named President-Elect. We express to Dr. Brown the appreciation of all of us for his fine, evenhanded leadership and the steady course he has set for the Society. We wish Dr. Weyl well, confident that he will be an outstanding President in these momentous times. We congratulate Dr. Hagood, who is well known to all of us and whose capabilities and extensive experience in the affairs of the Society have been demonstrated on many occasions. The Medical Society of Virginia will continue to be in strong, safe hands.

During all of this, nature has gone on her way as she has since time began, unhurriedly and unchanged by all of the bustle and excitement. Season has succeeded season, so now the trees are etched sharp and bare against a winter sky and the ground is barren. Ice must be scraped from windshields, golf clubs have been shifted from car trunk to closet and water sports are vicariously enjoyed through *Yachting* magazine. But counterbalancing is the bracing air, hunting season, toothsome oysters and succulent fresh fruit from Florida.

Moreover, December encompasses our most meaningful and joyous holiday season. The staff of The Medical Society of Virginia and the VIRGINIA MEDICAL MONTHLY wish you and yours a very inspiring and merry Christmas and a very profitable and happy New Year.

So, winter, do your worst. The months, seasons and years will continue their relentless progression regardless of politics, calamities or triumphs.

"O Wind, If winter comes, can spring be far behind?"
Shelley: *Song to the Men of England* (1819).

W. T. Thompson, Jr., MD, Editor.

The Journal Provokes Reader Comment

Congratulations on the October issue and the "Salute to Dr. Harry J. Warthen." It was my good fortune to be on the MCV service with Dr. Warthen as attending surgeon during his first years in Richmond. I learned much from his teaching and marvel at his sustained interest on behalf of the history of medicine.

Keep up the good work. The diversity of related medical and editorial material from many sources makes interesting, informative reading for everyone and pride for our Virginia.

P. N. Pastore, MD,
Richmond, Virginia

I was truly overwhelmed by the color reproduction of the figures for my article in the September issue of VIRGINIA MEDICAL.[1] Without any hesitation I can say that these are the most impressive of all the figures of my previous articles published in six or seven different medical journals. I am deeply grateful and wish to congratulate the Editors.

It is not only the typography of the journal that is impressive. The material published in it is also of international appeal. You will be pleased to know that I have received reprint requests from as far away as South America, Japan and Czechoslovakia.

Khalid J. Awan, MD,
Norton, Virginia.

1. Awan KJ: Dacryohemorrhea: the phenomenon of tears of blood. Va Med 103:643, 1976

A worthy journal in our town,
Has a name without a noun,
Foreign readers to perplex,
Causing staff of staid *Index*
Medicus to groan and frown.

Hampton R. Bates, MD,
Richmond, Virginia.

I am sorry, but I do not like the new format of the VIRGINIA MEDICAL MONTHLY. I think when a journal is overwhelmed by advertisements scattered throughout the articles it automatically prostitutes itself to the caliber of the "throw-away" journals. All change is not for improvement, and I think this is a step backwards. Follow the example of the *New England Journal of Medicine.*

Thomas W. Sale, MD,
Hampton, Virginia.

LETTERS TO THE EDITOR

The present format of the journal and the topics selected are interesting, and I am enjoying it.

Michael J. Moore, MD,
Salem, Virginia.

Wow! The journal sure is getting a face lift. Looks great. Congratulations.

William T. VanPelt,
Richmond, Virginia.

I have reviewed the latest issue of the journal, and I would like to compliment you on the new format. I think the journal is much more readable, and I particularly like the pictures, captions, and the historical articles.

Eugene R. Perez, MD,
Richmond, Virginia.

I was delighted to see Dr. Cimmino's editorial reflecting on the process of medical education. His comments are most appropriate in current trends of medical education and indeed are quite congruent with the goals and priorities of the Eastern Virginia Medical School, particularly as they relate to the superb opportunities for education in the community hospitals, which are indeed the sole base for clinical education for our students.

Having graduated our first class in September, I can testify from first-hand experience that education following the guidelines that Dr. Cimmino relates produces young men and women eminently prepared to enter their graduate educational experiences. I might add that they all passed the National Board examination, for whatever that is worth.

Robert T. Manning, MD,
Norfolk, Virginia

VIRGINIA MEDICAL OBITUARY

Walther Riese, MD

At the age of 86, Dr. Walther Riese, Richmond, died September 9. He was emeritus associate professor of neurology, psychiatry and the history of medicine at the Medical College of Virginia and a professor emeritus of the University of Frankfurt in West Germany.

A native of Germany who fled from Europe with his family in 1940, Dr. Riese was recognized internationally for his studies of the brain. He was a prolific author, writing 15 books and more than 260 articles in the fields of neurology, neuroanatomy, psychology and the history and philosophy of medicine. He joined MCV in 1941 as a Rockefeller fellow and remained there until he retired in 1960. He also served as consulting neuropathologist for Virginia's Department of Mental Health and Mental Retardation, as a consultant to the National Institutes of Mental Health, and taught at the Washington School of Psychiatry.

Dr. Riese belonged to The Medical Society of Virginia and to many other professional societies throughout the world.

His survivors include his wife, Mrs. Hertha Riese, a psychiatrist and author.

William Francis Collins, MD

At the age of 89 years, Dr. William F. Collins, Roanoke, died September 26 in a Roanoke hospital. He had been a general practitioner in Roanoke for 59 years.

Dr. Collins was graduated in 1911 from the New York University School of Medicine. He had been a member of The Medical Society of Virginia for 53 years. A daughter survives him.

Edward A. Houghton, MD

Dr. Edward Arnold Houghton, Annandale psychiatrist, died September 23 in Fairfax Hospital of cancer of the bone, which had first been diagnosed 2½ years previously. He was 38 years old.

Born in Arthurdale, Virginia, Dr. Houghton was graduated from Earlham College, Richmond, Indiana, a Quaker school, and took his degree of medicine from George Washington University. His internship was served at Fairfax Hospital and his residency at the Western Psychiatric Institute and Clinic, Pittsburgh. He first practiced at the Norristown, Pennsylvania, State Hospital, then moved to Annandale, where he practiced at the Springfield Mental Health Center and the Mt. Vernon Center for Community Health. Early in 1976 he entered private practice, specializing in the care of terminally ill persons, with emphasis on a mutual support group, "Make Today Count." He was a member of the Langley Meeting of the Religious Society of Friends.

His wife and three small children survive him.

Edgar M. McPeak, MD

Dr. Edgar M. McPeak, Washington, D.C., was 74 years old when he died of a heart attack in a Washington hospital on August 14. He had been a member of The Medical Society of Virginia for 50 years.

A radiologist, Dr. McPeak was born in 1901 in Hillsville, Virginia, and earned his medical degree at the University of Virginia. Prior to his retirement from private practice in 1971, he was chief of radiotherapy at Doctors Hospital, Washington. His memberships included the Southern and American Medical Associations and the American Roentgen Ray Society.

In 1939 Dr. McPeak began raising orchids as a hobby and eventually founded a thriving business, Kensington Orchids, Inc., retaining a partnership in that firm until his death.

His wife survives him.

Stephen John Beeken, MD

At the age of 68 years, Stephen John Beeken, MD, Christiansburg, died August 7. A member of The Medical Society of Virginia since 1937, Dr. Beeken was a graduate of the Medical College of Virginia, class of 1933. His specialty was general practice.

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KEY TO ABBREVIATIONS

cme — continuing medical education
e — editorial
h — history
l — literature
le — letter
* — medical article
ph — public health
pv — point of view
s — speech
sa — special article
msv — The Medical Society of Virginia

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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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